

PD-ABG-407

83338

Prepared for

Office of Population
Bureau for Research and Development
Agency for International Development
Washington, D.C.
under Contract No. DPE-3024-Z-00-8078-00
Project No. 936-3024

**EVALUATION OF THE FAMILY
PLANNING TRAINING FOR
PARAMEDICAL, AUXILIARY, AND
COMMUNITY PERSONNEL (PAC IIb)
PROJECT**

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Fieldwork
February 1 - 22, 1993

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Report No. 92-182-148
Published July 19, 1993

Table of Contents

Glossary	v
Project Identification Data	vii
Acknowledgments	ix
Executive Summary	xi
1. Introduction	1
1.1 Project Description	1
1.2 Project Goal and Objectives	1
1.3 General Characteristics and Overall Assessment	2
2. Strategies, Needs Assessments, and Training Plans	3
2.1 INTRAH	3
2.2 Development Associates	3
3. Implementation of Training, Quality and Comprehensiveness of Training, and Trainee Selection	5
3.1 Implementation of Training	5
3.2 Quality of Training	5
3.3 Priorities and Comprehensiveness of Training	5
3.4 Selection of Trainees	7
4. Training, Training Methodologies, and Materials	9
4.1 In-Service and Pre-Service Training	9
4.2 Methodologies	9
4.3 Materials	11
4.3.1 Production, Duplication, and Distribution of Contractor Materials and Technical Assistance for Local Production	11
4.3.2 Training Materials Database	12
5. Evaluation and Follow-Up	15
5.1 Evaluation	15
5.1.1 Development Associates	15
5.1.2 INTRAH	16
5.1.3 Need for Additional Evaluation	16
5.2 Follow-Up	16
6. Institutionalization	19
6.1 INTRAH	19

6.2	Development Associates	19
6.3	Conclusions and Prospects for the Future	20
7.	Other Impacts and Outcomes	21
7.1	Impact of Training	21
7.1.1	Family Planning Services	21
7.1.2	Supportive Environment	22
7.1.3	Policies and Norms	22
7.2	Project Outputs	23
8.	Management and Funding	27
8.1	Headquarters, Regional Offices, and Regional Advisors	27
8.1.1	Structure	27
8.1.2	Assessment of Staffing	27
8.1.3	Project Documentation	28
8.2	A.I.D.	28
8.2.1	Oversight	28
8.2.2	Priority Country Strategy	29
8.2.3	Family Planning, Family Health, and AIDS/Sexually Transmitted Diseases	30
8.3	Subcontractors	30
8.4	External Relationships	31
8.4.1	Overall Performance	31
8.4.2	Responsiveness to USAID Mission Needs	32
8.4.3	Overlapping CA Mandates	32
8.4.4	Relations between the Two PAC Contractors	32
8.5	Funding	33
9.	Design of Future Project	35
9.1	Overall Conclusion	35
9.2	Issues to be Addressed	35
9.2.1	Overall Project Design	35
9.2.2	Implementation of Training	36
9.2.3	Methodologies and Materials	36
9.2.4	Evaluation	36
9.3	Management	36

List of Tables

Table 1	Number of Countries and Institutions Receiving Support	24
Table 2	Number of Participants to be Trained (First and Second Generation)	25
Table 3	DA: Multiplier Effect of TOT	25
Table 4	Training Multiplier Effects: INTRAH Second Generation Trainees by Type of Training	26

List of Appendices

Appendix A	Description of Evaluation	43
	Attachment 1 Scope of Work	47
	Attachment 2 Bibliography	51
	Attachment 3 List of Persons Interviewed	55
	Attachment 4 Office of Population Questionnaire to Missions Regarding PAC IIb Performance	59
Appendix B	Selected Features and Progress to Date of INTRAH Training Projects in Eight Focus Countries	61
Appendix C	Selected Features and Progress to Date of DA Training Projects in 14 Countries in the LAC and ANENA Regions	65
Appendix D	Funding Mechanisms in DA Countries	67

Glossary

ADOPLAFAM	Dominican Association for Family Planning (Sp.)
A.I.D.	Agency for International Development
ANENA	Asia, Near East, and North Africa (region)
AVSC	Association for Voluntary Surgical Contraception
CA	Cooperating Agency
CBD	community-based distribution
CD-ROM	compact disc-read only memory
CIES	Center for Studies in Research, Education, and Services (Sp., Bolivia)
DA	Development Associates, Inc.
FY	fiscal year
FPMD	Family Planning Management Development (project)
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
IST	in-service training
IT	Information and Training (division — Office of Population)
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
LAC	Latin America and the Caribbean
LOP	life of project
MCH	maternal and child health
METRACAP	Measuring Institutional Training Capability (evaluation instrument)
MOH	ministry of health (multiple countries)
NGO	non-governmental organization
PAC IIb	Family Planning Training for Paramedical, Auxiliary, and Community Personnel IIb (project)
PAC	paramedical, auxiliary, and community
PCS	Population Communication Services (project)
POPLINE	population on-line computer resource
POPTECH	Population Technical Assistance Project
PMI	maternal and child health (Fr.)
PROSALUD	For Health (Sp., Bolivia)
PST	pre-service training
REDSO	Regional Economic Development Support Office
SEATS	Family Planning Services Expansion and Technical Support (project)
SOMARC	Social Marketing for Change (project)
STD	sexually transmitted disease
TA	technical assistance
TOT	training of trainers
TRG	Training Resources Group, Inc.
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development (overseas missions)
WHO	World Health Organization

Project Identification Data

1. **Project Title:** Family Planning Training for Paramedical, Auxiliary, and Community Personnel (PAC IIb) Project
2. **Country:** Worldwide
3. **Project Number:** 936-3031
4. **Project Dates:** September 1989-September 1994
5. **Project Funding:** DA: \$22,934,626
INTRAH: \$22,967,544
6. **Mode of Implementation:** Contracts with INTRAH and DA
7. **Responsible A.I.D. Officials:** Lucy Mize and Estelle Quain, cognizant technical officers
8. **Previous Evaluation:** Review of the Family Planning Training Worldwide PAC II Project 1984-1987, May 27, 1988, POPTECH

Acknowledgments

The team would like to express its appreciation to the many persons who provided information, ideas, and assistance and were exceptionally generous with their time. Given the scope of the evaluation and the number of institutions visited, it is not possible to mention here all the persons the team would like to thank. A list of persons interviewed appears in Appendix A, Attachment 3.

Executive Summary

Background

The Family Planning Training for Paramedical, Auxiliary, and Community (PAC) Personnel project (PAC IIb) provides assistance to developing country institutions to develop their capacity to carry out effective, self-sustaining family planning training programs for PAC workers. The project concentrates on strengthening the clinical, training, and management skills of personnel who train, manage, or supervise PAC workers. It is important because it is the primary mechanism used by the Agency for International Development (A.I.D.) to provide training to PAC-level family planning workers. PAC workers are closest to clients in family planning delivery systems and greatly affect the quality, availability, and effectiveness of services.

PAC IIb, funded at approximately \$46 million, is implemented through two separate A.I.D. contracts: the Latin America and Caribbean (LAC) and the Asia, Near East, and North Africa (ANENA) regional contract was awarded to Development Associates, Inc. (DA); the sub-Saharan Africa regional contract was awarded to the Program for International Training in Health (INTRAH). The current project builds on and expands work accomplished under PAC IIa (FY 1984-FY 1989) and PAC I (FY 1979-FY 1983). At the time of this report, the project, scheduled to end in September 1994, was about two-thirds completed.

Evaluation of Current Project

Overall, both CAs are doing a very good, if not excellent, job of responding to project objectives — namely, to strengthen or develop the capacity of institutions to design, implement and evaluate training programs that prepare PAC workers to provide family planning services. The recommendations of this evaluation, therefore, are focused on improvements at the margin.

Strategies, Needs Assessments, and Training Plans

All INTRAH project activities are based on strategies, needs assessments, and training plans. As a result, the likelihood is good that its technical and other assistance in training will be effective and results (progress) can be readily measured. DA, on the other hand, does not appear to have institutionalized the process of developing strategies. Consequently, the existence of such documents varies from region to region. Although this does not mean that assistance is necessarily less effective, progress can be harder to assess.

Both CAs have done a very good job of implementing training strategies and plans. INTRAH excels at documenting the implementation of strategies and plans and has carried out much of its planned work in spite of weak institutional public sector structures in Africa and constraints created by significant reductions in planned funding. DA's work, particularly in India and the Philippines, has carefully followed strategies and plans and appears to be on target.

Comprehensiveness of Training and Trainee Selection

Both CAs have identified strengthening training capability as their first priority. INTRAH is also addressing training needs generated by advances in contraceptive technology. On the other hand, several topics appear to receive insufficient emphasis in PAC IIb curricula. These include training

in supervision techniques; use of service statistics; client counseling; use of surveys and focus group interviews; and targeting of adolescents and men. With regard to AIDS and sexually transmitted diseases, both contractors include some training in these areas as part of clinical training.

Appropriate cadres of workers are generally selected for training and both PAC contractors have provided trainees with required skills.

Quality of Training, Training Methodologies, and Materials

Both CAs have focused primarily on in-service training, although both have also assisted with pre-service training where appropriate and feasible. DA, for example, has provided pre-service training in seven countries.

Both CAs utilize training methodologies that reflect sound educational principles. Both rely on competency-based strategies measured against performance standards. Each CA uses a range of alternative training methodologies. The net result is that training assisted by both CAs is usually of high quality.

Both contractors have been involved in the production, duplication, revision and distribution of field-tested materials which are culturally and educationally appropriate for clients. Many materials have been translated into major languages. The CAs have also worked with staff of client institutions to develop their capability to produce materials.

Evaluation, Research, and Follow-up

DA and INTRAH have extensive strategies and methodologies to evaluate training. DA's overall evaluation plan serves as a framework for individual evaluation activities. DA has also recently developed an instrument, METRACAP, to assess institutional training capability. INTRAH's evaluation plan is a sophisticated, elaborate manual which covers project goal, purpose, inputs and outputs.

Institutionalization

Both CAs have given considerable attention to developing operationally useful definitions of institutionalization. Missions in all three regions gave positive feedback on the contractors' achievements in increasing capabilities and capacities in developing country institutions.

Other Impacts and Outcomes

Although the contracts for PAC IIb do not include a requirement that the contractors assess the impact of training on service delivery, both CAs have made considerable strides in this area. Both have demonstrated, more at the micro than the macro level, that their assistance to training activities has affected acceptor rates, method mix, numbers of referrals, and provider skills and knowledge. On the other hand, the CAs recognize that the ability of training to affect service is limited, given the interdependence of all factors that relate to effective delivery of services: trained staff, service supervision and support systems, commodity supply to service sites, country policies, and reproductive health strategies.

As part of their technical assistance in training, both CAs have done significant work in influencing policies, norms, and regulations with the objective of improving both quality and availability of family planning services.

With respect to quantitative project outputs, at approximately two-thirds of the way through their respective contracts, DA and INTRAH have made substantial progress in achieving targets. In the face of budgetary constraints, and considering the unforeseen changes stemming from A.I.D.'s Priority Country Strategy, both CAs are to be commended for their progress toward achieving and/or exceeding contract outputs which are critical to project success.

Management Structures and Processes

Both CAs have well-qualified, experienced staff at headquarters and in regional offices. USAID missions gave very favorable assessments of the efficiency and effectiveness of the contractors' regional office project management and technical assistance and the appropriateness of staff skills and experience. The INTRAH regional office in Nairobi, however, is understaffed in relation to the current workload and opportunities in the area. Missions were also very positive about the performance of contractors' staff in field situations, whether they were based in-country or functioned as consultants.

A.I.D. has presented some difficulties for both contractors. Senior staff of both CAs indicated that A.I.D.'s tendencies to participate in day-to-day management of project activities and to make frequent requests for information had negative consequences for the project's professional activities. The new Priority Country Strategy, which focuses on the larger countries within each region and which was developed after the PAC IIb contracts were awarded, has created considerable disruption and uncertainty on the part of both CAs with respect to current and planned work in each region and required them to reprogram a number of activities. In addition, A.I.D.'s existing organization, which has separate offices for health and for population and separate CAs for each of these areas, sometimes makes it difficult to provide integrated technical and other assistance to host country institutions that have established as a priority the development of "family health" as opposed to family planning services.

Both DA and INTRAH have collaborated effectively with other Office of Population CAs, donor agencies, and USAID missions. Where there have been issues of overlapping mandates, resolution of problems has been most effective when worked out at the country level. The two CAs seem to have had less collaboration and information sharing with one another.

Underfunding of both CAs has meant that each has been receiving about 65 to 70 percent of planned budgets. Although A.I.D. has been understanding and supportive, it may not be aware of the full impact in terms of the scaling down of planned targets and technical activities in various countries because of budget reductions; the endless cycle of replanning and rebudgeting; the stretching of CAs' manpower to the limit; and the difficulty of having a long-term planning horizon.

Principal Recommendations for Current Project

- 1) DA should articulate its philosophy and principles regarding development of needs assessments, strategies, and training plans to serve as a general guide for its work in all countries.

- 2) Although it is recognized that DA's scope of work in any country is constrained by USAID mission directives, DA should give increased attention to developing more comprehensive needs assessments and training strategies in all countries in which it is active.
- 3) INTRAH and DA should be encouraged, where possible, to urge inclusion of supervisory level staff in training courses for service providers. Supervision and the use of supervisory tools should also continue to be viewed as priority training areas.
- 4) INTRAH and DA should give increased attention to training PAC workers and their immediate supervisors in the use of existing service statistics for planning, managing, and evaluating family planning services.
- 5) Increased attention should be directed to training in counseling skills in those settings in which PAC workers are not focusing adequately on client choice.
- 6) A.I.D. should increase INTRAH's funding to permit hiring of additional professional staff in the Nairobi regional office.
- 7) The Office of Population should make a serious effort to reduce the amount and frequency of requests for information from the CAs.
- 8) The Office of Population should be less involved in day-to-day management of CA project activity.
- 9) A.I.D. should explore ways to integrate more effectively its work in MCH and family planning, particularly when providing support to ministries of health and other organizations that promote integrated MCH/family planning services.
- 10) Given the potential risks related to AIDS and sexually transmitted diseases (STD) to both service providers and clients, both contractors should ensure that in providing technical assistance in family planning training, adequate attention is given to AIDS/STDs.
- 11) Actual funding levels should be closer to planned funding levels.
- 12) A.I.D. should try to provide more stability for project funding.

Future Project: Continuation and Recommendations

Given the project's effectiveness in developing the capabilities and capacities of training institutions and given the importance of PAC workers as providers of family planning services, a follow-on project, with some modifications and additions, is clearly warranted.

Recommendations

- 1) Given 1) the diversity of the regions in which PAC training is required, 2) the depth of knowledge and experience the current CAs have in several regions, and 3) the advantages of competition, and 4) the usefulness of having more than one organization seek ways to improve training, A.I.D. should continue to use more than one CA in the next project.

- 2) The breadth of mandate for the next project should closely resemble that of the current one.
- 3) Regarding sectors (public, NGO, private) for PAC attention, the next project should continue the flexibility of the current one. Decisions regarding sectors to be assisted should be based on analyses of country situations.
- 4) Efforts should be made to provide integrated (not just family planning) technical assistance in training to those client institutions that focus on family health or MCH/family planning care. Given the prevalence and danger of AIDS/STDs to both clients and providers, training should address this area also.
- 5) USAID missions should be given information on a regular basis as to scope and competencies of the PAC CAs and should be encouraged to include the CAs in needs assessments and planning if the latter are to be involved in project execution.
- 6) The project CAs should be encouraged to continue their collaboration with other CAs in an effort to ensure that all necessary elements (supplies, management information systems, supervision, etc.) for effective family planning services are present.
- 7) Funding for the next PAC project should be increased. Further, actual funding should be close to planned funding. A moderate proportion of central funds (perhaps 15 percent) should be available for use in non-priority countries.
- 8) The CAs should provide essential medical equipment and supplies, including contraceptives, to ensure that trainees, following completion of training, have the requisite elements to put into practice what they have learned. PAC CAs should not, however, become a continuing source of such supplies.

1. Introduction

1.1 Project Description

The Family Planning Training for Paramedical, Auxiliary, and Community (PAC) Personnel project (PAC IIb) provides assistance to developing country institutions to develop their capacity to carry out effective, self-sustaining family planning training programs for PAC workers. The project concentrates on strengthening the clinical, training, and management skills of those personnel who train, manage, or supervise PAC workers. It is important because it is the primary mechanism of the Agency for International Development (A.I.D.) to provide technical assistance and training to PAC-level family planning workers. PAC workers are closest to clients in family planning delivery systems and greatly affect the quality, availability, and effectiveness of services.

PAC IIb, funded at approximately \$46 million, is implemented through two separate A.I.D. contracts: the Latin America and Caribbean (LAC) and the Asia, Near East, and North Africa (ANENA) regional contract was awarded to Development Associates, Inc. (DA); the sub-Saharan Africa region contract was awarded to the Program for International Training in Health (INTRAH) at the University of North Carolina. The current project builds on and expands work accomplished under PAC IIa (FY 1984-FY 1989) and PAC I (FY 1979-FY 1983). At the time of this report, the project, scheduled to end in September 1994, was about two-thirds completed.

This report is the final evaluation of this worldwide effort and is designed to document progress in the development of PAC IIb assisted agencies and institutions in their ability to institutionalize pre-service and in-service family planning training and education programs and to review the achievement of project objectives. It also identifies needs and provides recommendations regarding a follow-on project (see Appendix A for further details regarding the evaluation).

1.2 Project Goal and Objectives

As stated in the contract, the goal of the project is to increase the availability of family planning services through training. The purpose is to strengthen or develop the capacity and capability of institutions to design, implement and evaluate programs of training activities so that PAC workers will be able to provide family planning services. The project stresses the institutional development of existing institutions and agencies. Priority attention is to be given to training of trainers (TOT), service delivery skills, curricula development, instructional skills, and management and supervisory skills.

According to the contract, successful achievement of project objectives will be measured through the following indicators:

- identification and utilization of effective strategies to increase the training capabilities and capacity of developing country institutions and agencies;
- ability of assisted institutions to maintain training programs with decreased technical support;

- number of national nursing, midwifery and auxiliary curricula that have been revised to include family planning and have been approved by regulatory bodies;
- an increase in the numbers of PAC personnel who are trained and trained to train others and are providing family planning services as a result of project activities;
- quality and relevancy of family planning training and training materials as applied to different levels of PAC workers;
- degree to which training programs include supervised practical experience; and
- coordination with other agencies to capitalize on existing human and material resources.

1.3 General Characteristics and Overall Assessment

PAC IIb training has several distinguishing characteristics. Both contractors tend to focus primarily on in-service training, targeting directly those individuals who are involved in the day-to-day management, supervision, and implementation of family planning programs, although both also undertake pre-service training where appropriate and feasible. Their activities are a mix of direct training and technical assistance provided by headquarters, regional office staff, and/or consultants, and the approach used depends on the circumstances. For example, direct training to train trainers is provided when host country trainers do not have the needed skills or essential knowledge. Technical assistance is provided where feasible and appropriate, as, for example, on how to plan for evaluation of a training activity. Both contractors develop training capability through training of master trainers, a small number of individuals who in turn train "first generation" trainees — service providers, supervisors, and managers — in both how to better carry out their roles and in some cases to train others. This training in turn spawns training of "second generation" trainees, who are trained by PAC IIb trained personnel but without project support or financing.

Because of the geographic areas served by the two contractors, the focus of their training differs somewhat. The contract calls for both contractors to work with both government and non-governmental organizations (NGO). In Africa, where PAC workers are more likely to be attached to ministries of health, INTRAH focuses primarily on working within the government program. In the Latin America region where many PAC workers are outreach staff employed by NGOs, DA's efforts are more often directed to these private sector entities. This also affects the focus of training: Since in Africa, government programs tend to be clinic based, INTRAH's training is more likely to emphasize clinical skills whereas DA, particularly in Latin America, is more likely to train outreach workers to provide temporary methods in rural areas.

In terms of performance, both Cooperating Agencies (CA) are doing a very good, if not excellent, job of responding to project objectives. Not only are most quantitative goals being met or exceeded, but equally important, the focus on non-quantitative objectives has been strong. As described below, these include development of needs assessments, strategies and plans; institution building; and attention to priority areas of training (TOT, service delivery skills, curricula development, instructional skills, and management and supervisory skills) and to quality and relevance of training. The recommendations that follow are, therefore, principally suggestions for improvements at the margin.

2. Strategies, Needs Assessments, and Training Plans

2.1 INTRAH

All INTRAH project activities are based on training strategies, needs assessments, and training plans. To ensure that they are, INTRAH has done an exceptional job of developing and applying a conceptual framework that sequences its activities, from needs assessment to assessment of impact on service delivery. This methodology, called by INTRAH "family planning training and service system development," greatly increases the likelihood that its technical and other assistance in training will be effective. Specific steps included in the system are as follows:

- identification of deficits and strengths in family planning resources, as baseline and planning data;
- development of linked national training and service expansion strategies;
- preparation of national service policies and procedures guides, curricula, training materials and other documents;
- planning and implementation of training and simultaneous building of host country training capability and capacity;
- deployment of trained workers to targeted service delivery sites, with essential service equipment and an initial supply of contraceptives to begin providing services immediately; and
- post-training performance evaluation and measurement of impact on services.

In developing strategies and plans for specific countries, INTRAH staff take into account country family planning program strategies, where they exist. Most of the countries in which it works have such strategies, based on needs assessments and typically developed by ministries of health (MOH) or USAID missions or through collaborative efforts of host countries and donor agencies. INTRAH has participated in development of some of these strategies.

The effectiveness of INTRAH's approach as applied to several African countries is illustrated in a matrix that INTRAH prepared for this evaluation, which illustrates well the clarity and comprehensiveness of its training approach (see Appendix B).

2.2 Development Associates

DA does not appear to have institutionalized the process of developing strategies, needs assessments, and training plans as an organizational mandate, i.e., it does not require written strategies, needs assessments, and training plans in all situations. Thus, the production and existence of such documents vary from region to region. In Latin America, for example, in assisting NGOs, DA may not undertake a countrywide needs assessment and develop a strategy because 1) the U.S. Agency for International Development (USAID) mission may not favor such a step; 2) the government may

be perceived as the appropriate entity for spearheading such an effort; and/or 3) the scope and significance of the NGO's program activity may be too small to warrant an effort of so broad a scope. In addition, DA's long-term presence and experience in a country may lead it to conclude that development of a country strategy is not necessary. In other cases, DA has been adept at responding to requests made or supported by local USAID missions for training that fits into a countrywide training strategy, even though DA was not asked to help develop that strategy. In Yemen, for example, DA developed a training program that fit well into the USAID's country strategy, calling for in-depth, broad-based technical assistance that involved a multi-agency training approach to improve training, counseling, and evaluation of family planning program initiatives. In new countries, DA usually conducts extensive assessments, the outcome of which form part of country strategies. The work documents for Turkey and India exemplify careful, thorough strategic planning that includes job descriptions, competency definitions, standards, and evaluation processes and reflects the USAID country strategy on population.

Although DA may not have formulated a needs assessment and a substantive overall country strategy, this does not necessarily mean that its assistance is less effective. On the other hand, the absence of assessments and strategies could result in failure to identify training activities that might be critical to improvement of family planning services in a given country. In addition, lack of articulated strategies makes progress harder to assess.

Recommendations

- 1. DA should articulate its philosophy and principles regarding development of needs assessments, strategies, and training plans to serve as a general guide for its work in all countries.¹**
- 2. Although it is recognized that DA's scope of work in any country is constrained by USAID mission directives, DA should give increased attention to developing more comprehensive needs assessments and training strategies in all countries in which it is active.**

¹Recommendations that appear in boldface type are the principal recommendations in this report and are listed in the Executive Summary.

3. Implementation of Training, Quality and Comprehensiveness of Training, and Trainee Selection

3.1 Implementation of Training

Both CAs have done a very good job of implementing training strategies and plans. INTRAH excels at documenting the implementation of strategies and plans and has carried out much of its planned work in spite of weak institutional public sector structures in Africa and constraints created by significant reductions in planned funding (see Section 8.5). In Cameroon and Kenya, INTRAH's selection of personnel for training is in accordance with training needs assessments and training plans. DA's work in India and the Philippines has carefully followed strategies and plans and appears to be on target. The USAID mission in Bolivia praised DA's work in helping to implement training plans for rural workers in Cochabamba.

3.2 Quality of Training

In general, the quality of training provided by both contractors appeared very good, including training methodologies, training materials, selection of trainees, training evaluation, and trainee follow-up (all discussed below). Both PAC contractors provide trainees with appropriate skills and relevant courses, according to all the missions queried in connection with this evaluation.

The high quality of INTRAH training was evident from observations of trained service delivery providers in Cameroon and Kenya. Training was competency based and trainees were generally given needed knowledge and skills. Likewise, DA training observed in Bolivia appeared to be of high quality, reflected in the enthusiasm of the faculty and student body, the content and level of discussion, and the questions raised by participants. The Bolivian NGO, PROSALUD (For Health), attributed much of its strength to the quality of DA technical assistance even though this assistance focused on a limited segment of PROSALUD's current program.

3.3 Priorities and Comprehensiveness of Training

Both contractors see strengthening training capability as their first priority. INTRAH defines this as developing skills in training needs assessment, use of performance assessment findings, on-the-job trainee follow-up, improved supervision, and clinical skills updates through continuing education. In addition, INTRAH has consciously addressed the issue of additional training needs generated by advances in contraceptive technology. Its reference for trainers, *Guidelines for Clinical Procedures in Family Planning*, includes information on the new implant, Norplant, and in East Africa, it has collaborated with the Association for Voluntary Surgical Contraception (AVSC) on introduction of longer-term and permanent methods. In West Africa in 1992, INTRAH sponsored a regional clinical update, coupled with a symposium on contraceptive technology, in collaboration with Family Health International.

DA's approach to strengthening training capability can be clearly seen from examples of activities in Asia and the Middle East. The country training strategy for India, for example, lists a threefold plan to institutionalize training capabilities by training a corps of master trainers, developing a family

planning training system in Uttar Pradesh for training auxiliary nurse midwives, and assisting the Indian Rural Medical Association in enhancing its family planning capabilities. In Yemen, by contrast, the plan details priority areas of training that include pre-service training and in-service training, the development of key private sector institutions, and the expansion of numbers of trained community outreach workers. In the area of training for new contraceptive methods, DA's policy is to provide technical assistance to incorporate all family planning methods that are appropriate and available in individual countries.

At a more concrete level, several topics appear to receive insufficient emphasis in PAC IIb curricula. Most critical among these is training in supervision techniques. Other areas include use of service statistics; client counseling; use of surveys and focus group interviews; and targeting of adolescents and men.

The inadequacy of supervision is cited frequently as a major weakness of both public and private sector family planning programs in all regions. As a result, both CAs view supervision as a priority area of training. At the same time, it is increasingly recognized that training alone does not necessarily strengthen supervision in the absence of other critical elements such as adequate numbers of supervisory staff, written procedures for supervision, existence of adequate transport to undertake supervision, etc. One response of training CAs has been to include supervisory-level staff in training programs for service providers to enable the supervisors to understand better the kinds of supervision they should exercise. INTRAH has done this in some of its work in East Africa. Other INTRAH-supported activity related to supervision includes technical assistance to service providers by district and regional supervisors, supervision and service monitoring training, and performance evaluation. In Burkina Faso, INTRAH is collaborating with the Family Planning Management Development (FPMD) project in development, testing, and implementation of supervision protocols based on service delivery with FPMD and INTRAH assistance. Staff of AVSC have recently proposed that training in Kenya be done principally by strengthened supervisory systems of a supportive character rather than through organized training programs. This approach is advocated on the grounds that training programs typically do not reach all the staff in a given clinic setting, that training programs are difficult to institutionalize, and that training tends to be episodic rather than continuous. Although the concept of "training through supervision" is a powerful one which warrants increased emphasis, the reality of staffing levels and transport constraints in the public sector in most of Africa and probably elsewhere suggests that this is not an either/or proposition.

With respect to the other areas mentioned above:

- 1) **Family planning statistical information** collected by service providers is valuable not only for supervision and project management purposes but also for planning and management at facilities. In addition, it is a potential motivating mechanism for workers. Service personnel and first-line supervisors, however, often lack full understanding of the significance of statistics, including how to utilize them or how to draw conclusions from them for improving services. In Kenya and Cameroon, for example, staff and supervisors maintain family planning statistics but appeared not to have a good idea how these statistics might help them improve the operations of their clinics. They saw them only as a way to know whether the number of clients was increasing.

- 2) **Client counseling** does not always offer clients an adequate range of contraceptive choices. Insufficient attention is paid to informing clients about the methods that are most suitable for them and offering them those methods.

3) **Assessing the effectiveness of family planning information and education by using simple techniques such as surveys and focus group interviews** could help PAC workers improve their information, education, and communication (IEC) efforts. If providers were to meet with various client groups, or to survey them, they could learn about the effects and effectiveness of their techniques and better understand attitudes, perspectives, and beliefs of the communities they serve. This information would aid providers to develop appropriate IEC strategies and effective personal styles and methods for communicating about family planning.

4) **Adolescents and men** are among target groups that seem generally to receive insufficient focus in PAC worker strategies and services. In many countries, for many reasons, family planning programs themselves do not make efforts to include adolescents and men in counseling and method provision. In instances in which they do, however, this focus needs to be reflected in the training.

Recommendations

3. **INTRAH and DA should be encouraged, where possible, to urge inclusion of supervisory level staff in training courses for service providers. Supervision and the use of supervisory tools should also continue to be viewed as priority training areas for all relevant levels of staff and CAs should attempt to ensure that supervisory protocols exist or be developed. Training CAs should explore the possibility of assistance from the FPMD project in this area.**

4. **INTRAH and DA should give increased attention to training PAC workers and their immediate supervisors in the use of existing service statistics for planning, managing, and evaluating family planning services. FPMD is a likely source of technical assistance and materials in this regard.**

5. **Increased attention should be directed to training in counseling skills in those settings in which PAC workers are not focusing adequately on client choice.**

6. **Providers and their supervisors should receive training in conducting simple surveys, focus group interviews, etc., to better understand and assess the impact of their work with communities.**

7. **Both CAs should give increased attention to strategies for reaching currently overlooked target groups such as adolescents and men.**

3.4 Selection of Trainees

Nearly all of the USAID missions queried indicated that appropriate cadres of workers have been and are being selected for training. In the Dominican Republic, for example, instructors from all 25 nursing schools have received training in teaching methodologies as well as reproductive health and family planning methods. Moreover, as a direct result of DA's activities, the International Planned Parenthood Federation (IPPF) affiliate in Guatemala, APROFAM, has been able to recruit and train more Mayan staff, who in turn are serving more hard-to-reach Mayan couples. Reports from USAID missions in Yemen, Ecuador, and India confirm the selection of appropriate personnel, including community-based distribution (CBD) workers in Ecuador and selected physicians in India who have received training in oral contraceptive promotion and clinical aspects. In the Philippines, USAID/Manila notes that DA is focusing on private sector midwives who are already providing

services in the community and notes further that training has a practical orientation, as it is geared toward introducing family planning in the package of services the private midwives can offer.

Likewise, many of the USAID missions in countries where INTRAH is working (Rwanda, Burkina Faso, Cameroon, Tanzania, and Uganda) give this contractor high marks in this area. For example, in Burkina Faso, INTRAH's work with the MOH has resulted in the use of formal guidelines to select participants. In Cameroon, candidates for training are screened for appropriate educational and practical experience. In Togo, although candidate selection criteria have not yet been clearly defined, the mission has commended INTRAH on its persistence in raising and keeping this issue before the government. As would be expected in this region, the A.I.D. Regional Economic Development Support Office/Eastern and Southern Africa (REDSO/ESA) and the mission in Rwanda stress that although trainees and training may be highly appropriate, host country officials "do not always strictly apply these criteria" when nominating service providers to attend courses (REDSO comment).

4. Training, Training Methodologies, and Materials

4.1 In-Service and Pre-Service Training

The project calls for the contractors to focus on both in-service and pre-service training. The strategy for both CAs therefore was to begin with TOT activities to increase capability for training various categories of family planning personnel including physicians, nurses, midwives, medical assistants, auxiliaries, community workers, CBD workers, and indigenous and traditional health workers. According to the contract, particular attention was to be given to supervisors, managers, faculty of pre-service training institutions, and other high-level health staff.

The major portion of the work of both CAs has been in the area of in-service training. Both have also assisted with pre-service training where appropriate and feasible and both might have done more in this area had not staffing and budget constraints precluded their responding to all requests. In all eight African countries shown in Appendix B, for example, INTRAH has developed training plans for in-service training whereas it has plans for pre-service training in only two of these. Likewise, DA has developed in-service training plans in all 14 of the countries shown in Appendix C, whereas it has pre-service plans in only 7. In Bolivia, DA has provided technical assistance in curriculum design to the School of Public Health for the course for auxiliary nurses. This has resulted in a significant increase in family planning content and major changes in the maternal and child health (MCH) curriculum also. Other DA examples include a strategy for strengthening pre-service family planning training for midwives in Turkey and nurse professor training in Brazil. In the Dominican Republic, DA, with ADOPLAFAM (the Dominican Association for Family Planning), plans to train 90 nursing school instructors as well as to assist instructors to develop a standardized family planning training curriculum for each category of nursing personnel.

INTRAH is receiving increasing numbers of requests for technical assistance in pre-service training, an encouraging trend that reflects governments' increasing commitment to educating medical personnel about family planning. In Cameroon, the director of pre-service training has requested INTRAH assistance with revision of the nation's pre-service training curricula, specifically in the area of methodology. Similar requests have been received from Togo and Burkina Faso. In Uganda, the INTRAH resident advisor has been working with staff of both Makerere and Mbarrara Medical Schools (baccalaureate nursing students at the former and physicians at the latter) to ensure that students of both receive training and practice in family planning. INTRAH is also working in pre-service training in Tanzania.

4.2 Methodologies

Both CAs utilize training methodologies that reflect sound educational principles. Both rely on competency-based strategies measured against performance standards. The net result is that training assisted by both CAs is usually of high quality.

Training methodologies used by INTRAH are based on a very well-thought-out conceptual framework with clearly identified learning objectives and high performance standards. Methods used vary by learner population and are geared to improving knowledge, skills, and attitudes. Interactive, participatory training methods emphasize skills development.

DA's strategy is to ensure that all training it provides is competency based. It develops lists of objectives for its training efforts whether they be in provision of clinical methods (which lends itself to this approach) or in management, supervision, TOT, or evaluation (more difficult to identify and measure objectives). DA has worked closely with the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) and the Population Communication Services (PCS) project in India to develop three curricula in that country. Two NGOs that DA has assisted in Bolivia, CIES and PROSALUD, use DA methods for all their training and have found them to be sound and adaptable to various learner populations.

Both contractors are working to improve the quality of training that is provided in their training workshops. In contrast to the passive, non-participatory approach common in many developing country settings, both INTRAH and DA are trying a number of approaches to involve the trainees in the learning process. For example, trainees are encouraged to discuss relevant experiences with other trainees, to practice teach and to observe other trainees teach, and to participate in socio-dramas. Likewise, using models, they are required to demonstrate their ability to carry out clinical procedures after observing the trainer do them.

In addition, alternatives to workshops have been explored and tested by both contractors. For example, DA plans to introduce a self-paced home study program for physicians in India. Historical precedence exists for such a method in Indian education, and the physician population expressed interest in adapting this method for use in reproductive health and family planning training. DA is deliberately focusing on techniques other than workshops, which can be expensive and inefficient for some learner groups.

A key aspect of training for both contractors is helping supervisors learn how to provide continuing on-the-job training to service providers who have been trained through the project.

For supervisors to acquire skills in conducting on-the-job training, however, takes time and practice. INTRAH includes on-the-job trainees follow-up in each of the country training projects. The visits are made within six months after training by master or central training team members with local supervisors, with or without INTRAH technical assistance, depending on the extent of local capacity and capability in performance assessment and problem-solving. In Tanzania, INTRAH with Ministry of Health trainers and local supervisors are routinely visiting newly trained clinic-based service providers to help them establish or strengthen services. These follow-on visits occur within six weeks after training. As part of this effort, the trainers closely involve supervisors, discussing the newly trained providers' work and devising on-the-job training interventions and any follow-up activities that might be appropriate to address any needs identified. INTRAH's work in West Africa was impressive, both the skill with which the master trainers identified needs and developed remedial action and the effect this had in strengthening the training-to-service delivery link. To assist in the process of on-the-job follow up, both DA and INTRAH have created job aids such as check lists, work sheets, data forms, etc., which they use in checking work. This on-the-job training process is frequently repeated at a later date to reinforce skills and improve the ability of supervisors to ensure that providers maintain the standards taught during training. Not all settings have developed the supervisory capacity to operationalize this component, however.

4.3 Materials

4.3.1 Production, Duplication, and Distribution of Contractor Materials and Technical Assistance for Local Production

Both contractors have been involved in the production, duplication, and distribution of appropriate field-tested training materials which are culturally and educationally appropriate. Many of these materials have been translated into the major languages and include materials for learners with limited ability to read and write. The CAs have also worked with appropriate staff of client institutions to develop their capability to develop training materials. Local capability in materials development has been promoted through the CAs' work in Bolivia, Cameroon, Guatemala, India, Kenya, Peru, and Uganda.

DA has provided technical assistance to increase local capabilities in both Bolivia and Peru, for example. In both countries, curricula developed by training committees in conjunction with DA have been adapted for use nationwide. DA also worked with APROFAM to develop exercises for low-literacy people and has provided training in desktop publishing. DA has distributed a total of 12,545 training-related items, principally to 12 countries in the LAC and ANENA regions.

INTRAH, which has focused on clinical training, has provided technical assistance for production of materials related to clinical methods. In Tanzania, for example, it worked with Tanzanian health and family planning professionals to develop and produce protocols and guides. INTRAH's training materials are highly regarded and the organization receives many requests for replication. For example, it is providing some 3,000 of the guides and protocols developed in Tanzania to assist Tanzanian training staff. Since the project's start through September 1992, INTRAH distributed some 25,425 items, principally to 14 countries. INTRAH has also been requested to assist in a needs assessment to determine requirements for training materials. For example, the WHO Health Learning Materials project in Kenya is requesting assistance from INTRAH's East Africa regional office for such an assessment for managers of divisions of the Ministry of Health and their communication experts. The goal is to determine the needs of the Kenya Health Learning Materials Project and provide a plan for production of these materials. WHO will shortly confirm INTRAH as a collaborating center for development of health learning materials over a four-year period.

Training materials are generally provided for all training exercises, although all sites visited requested more materials and several sites expressed a need for a broader-based set of reference materials for faculty in pre-service training. Such materials tend to find their way off the shelf to sites unknown with frustrating regularity, and thus the need for sufficient materials remains. In West Africa, the INTRAH reference libraries and clinical resource libraries appear to be appreciated and well utilized.

Models and materials such as IUD insertion kits, training commodities, slides, videos, etc., were requested in several LAC sites, including the Dominican Republic and some training sites in Bolivia.

Recommendation

8. A.I.D. should increase funding to both contractors to assure adequate supplies of reference materials for the institutions they assist.

4.3.2 Training Materials Database

In 1988, under the PAC IIa project, DA initiated development of a training materials database to serve as an information source and reference guide for family planning materials. The purpose of the database is both to enable training professionals to avoid duplication of effort when creating materials for use in conjunction with family planning programs and to facilitate distribution of materials.

The database contains only listings of materials developed by A.I.D.-funded organizations. Many of these are unpublished training manuals that are unavailable from other sources. Materials developed at the country level with or by assisted institutions are rarely included, due to the requirement that authors or institutions must make the materials available to those who request them. This is often a problem at the country level, since many host country institutions do not have the financial resources for reproduction and mailing.

All materials developed by INTRAH's headquarters and regional offices appear to be included in the DA database. Since INTRAH is known for having a large collection of family planning materials, the inclusion of these items provides an additional dissemination mechanism.

DA distributes loose leaf notebooks containing summary database information to a total of 65 recipients (other CAs and USAID missions) worldwide. New and updated information on the database is mailed out to these recipients on a quarterly basis. Entries within the database are indexed by language and divided into 15 subject categories containing abstracts of the materials and information on how they may be ordered. In addition, DA will conduct database searches upon request for readers who desire more information than that provided in the abstracts.

Limiting information on the database to other CAs and missions means that host country institutions that could potentially use and benefit from such materials are excluded unless they have access to the database through in-country CA organizations. For DA to be able to offer the database and information searches to these additional institutions, however, funds for reproduction, mailing, and shipping would need to be made available.

The usefulness of the database cannot readily be determined. Since November 1991, DA has received 131 requests for information and database searches from CAs and their affiliates. A review of a small sample of these requests indicated that it is being used both by A.I.D., USAID missions, and the other CAs that have direct access to the database and by universities and country-level agencies and institutions that have access through the 65 institutions that receive the database notebook. DA does not serve as a clearinghouse; requesters must obtain the materials themselves directly from the authors or institutions and can do so without informing DA or requesting a DA database search. In such instances, neither DA nor the author or institution may be aware that the impetus for the request was the training materials database.

In some locales, DA's database notebook may not be well known by all. In Bolivia, for example, although both the USAID mission and the FPMD coordinator had copies and were aware of its function, the Population Council representative did not know of its existence. Thus, in some instances, dissemination of the database notebook may not extend beyond the headquarters of CA organizations.

At the time of this evaluation, DA was in the process of conducting an evaluation of the database and had mailed out questionnaires to all those in possession of the notebook. DA is also exploring the possibility of disseminating the database using compact disc-read only memory (CD-ROM) technology and is holding discussions with the population on-line computer resource, POPLINE, regarding CD-ROM development and distribution.

Recommendation

9. DA should consider extending distribution of the database to some host country training institutions. DA could test the idea by distributing the database to such institutions in a few countries. A.I.D. should ensure that DA has sufficient funds to accomplish this.

5. Evaluation and Follow-Up

5.1 Evaluation

5.1.1 Development Associates

DA has developed an excellent practical capability in the area of evaluation, based on the extensive strategy it has created. This includes an overall evaluation plan which serves as a framework for individual evaluation activities. Evaluation topics are selected based on the contract, the types of training activities, and ongoing needs assessments.

The DA evaluation team works in collaboration with other technical staff in developing project design to ensure that evaluations plans are included. To a great extent, the evaluation plans are based on country strategies and workplans. All evaluation activities are undertaken in conjunction with host country personnel, with the express purpose of helping train these individuals in evaluation approaches and techniques. For example, in India, DA evaluators have worked with the Indian Medical Association on assessing the impact of training, i.e., the success of the training as judged by the ability of the trainees to carry out what they have been trained to do. To assist in making such judgments, the evaluation project in India includes a handbook of uniform indicators and definitions. In Bolivia, DA with CIES completed an evaluation on the impact of advanced skill training on CBD worker productivity and dropout rates. In the Philippines, DA trained host country trainers in how to develop evaluation research methodologies; this led to the development of a long-term training evaluation research strategy. In Lebanon, DA provided technical assistance to host country supervisors on how to assess the impact of IUD training for clinicians of the Lebanese Family Planning Association, and work is proceeding on a training evaluation curriculum for use in regional and in-country workshops.

In addition to efforts to assess the effectiveness of specific training efforts, DA has recently developed an instrument, Measuring Institutional Training Capability (METRACAP), that is designed to evaluate the level of training competence of host country training institutions. Designed to measure the impact of DA-sponsored activities, the instrument was found in field testing to also have potential as a self-assessment tool and as a needs assessment guide. METRACAP contains indicators for measuring training capability and for gathering information on training capacity.

Overall, DA's evaluation projects are thoughtful and useful, reflecting the aim of improving training activities, service delivery skills, retention of workers, and user acceptance and continuation rates. The results of DA's evaluations are communicated in a manner that promotes incorporation of findings in planning and training activities and is rated highly by the recipients. Technical evaluation staff noted that in some instances they had difficulty in having special study projects approved (e.g., an effort to field test a new technique), particularly as there is no provision for line items for such unanticipated activities. In addition, lack of funds has slowed efforts to apply METRACAP to field situations.

5.1.2 INTRAH

Like DA, INTRAH has developed an excellent capability in evaluation, exhibited in a comprehensive system for training evaluation. INTRAH's evaluation plan is a sophisticated, elaborate, two-volume manual based on project goal, purpose, outputs, and inputs. Individual evaluation workplans are developed using indicators of achievement for what, why, how, who, when, and where. All plans follow a detailed policy with regard to reporting, utilization of results, and further planning. In the Nakuru district, Kenya, in a December 1992 performance skills evaluation assessment, Ministry of Health personnel who had been trained by INTRAH demonstrated that they had successfully internalized these principles, making changes in training based on the evaluation of the performance of graduates of an earlier training program. The assessment involved selecting a sampling of trainees for follow-up. INTRAH provided technical assistance for the development of supervisory objectives and evaluation tools and master trainers developed four instruments to cover counseling, physical diagnosis, pelvic examination, and insertion of IUDs. Using these instruments, four master trainers and four field supervisors evaluated the 100 selected service providers, analyzed the results and drew up recommendations to strengthen on-the-job training.

INTRAH's consistent practice of collecting data on impact of training (i.e., how well skills were learned) and utilization of evaluation findings reflect the organization's commitment to evaluation. Future plans for evaluation include increasingly sophisticated approaches to evaluating the quality of the training sessions themselves; evaluations looking at the impact of training on service delivery, both quantitative and qualitative; performance evaluation workshops; and evaluation of the various new approaches to training methodologies described above to learn which are most appropriate for individual cadres.

5.1.3 Need for Additional Evaluation

A consistent theme during field visits was the request for further technical assistance on evaluation. Field staff appeared to understand the principles of evaluation and to accept the need for it but expressed the need for additional guidance. In short, the motivation for evaluation has been instilled but institutions in most PAC IIb countries will need continuing technical assistance.

5.2 Follow-Up

Significant evidence exists that both contractors have addressed the need to develop systems to locate, track, and evaluate trainees (i.e., assessing how they are performing on the job). DA has provided assistance to PROSALUD in Bolivia for follow-up of health and family planning providers. This included designing instruments and assisting with organization of a trainee follow-up system. In Brazil, a system for evaluation and follow-up was introduced in the nursing schools that DA is assisting. The project for increasing institutionalization of family planning as part of pre-service education in the Philippines includes a comprehensive evaluation process encompassing assessment, observation, and follow-up. In India, newly trained physicians use a system of postcard follow-up, enabling the training entity to keep track of numbers of acceptors, method mix and problems the trainees encounter.

In Africa, INTRAH's regional offices assist ministries of health with follow-up of trainees. In Cameroon, biographic data forms are used at the national and regional levels, with the MOH family planning coordinator responsible for collecting and evaluating the data. In Tanzania, trainees make

use of a follow-up feedback form, completing it and sending it back to the trainers for review. The Nairobi regional office is unable to meet all the demands for trainee follow-up, however, due in part to INTRAH staff shortages (see Section 8.1.1 below).

Although both CAs direct considerable attention to follow-up of trainees, USAID missions had mixed views with respect to the type and sufficiency that are actually provided. Several missions described how the contractors planned to provide follow-up. The mission in Burkina Faso stated that INTRAH has improved its previously weak follow-up activities, having instituted a reporting system as a means by which to follow participants. With regard to DA, a follow-up tool in the form of formal workplans was mentioned by the USAID mission in Ecuador as a way in which trainees will evaluate accomplishments and identify needs. In the Philippines, USAID pointed out that post-evaluation surveys are conducted every six months and that plans are being made to conduct bi-annual refresher training.

In many cases (in Togo, Rwanda, Uganda, Peru, the Dominican Republic, and Yemen), mission staff or REDSO noted room for improvement. Specifically, in Uganda, USAID indicated that although follow-up does occur, the MOH training coordinator had expressed the view that it was "not sufficient in duration, frequency and timeliness." In Peru, the mission indicated a need for formal programmed follow-up plans, and in the Dominican Republic, USAID stated that a follow-up plan had not yet been developed. The mission in Yemen indicated that DA's follow-up activities include visits to participants' work sites and field testing of its evaluation instrument but also noted that additional follow-up and monitoring activities are needed.

Recommendations

10. Since nearly all sites visited requested further technical assistance on evaluation, evaluation needs assessments should be geared to providing host institutions with the skills required.
11. Provision should be made for budget line items for special evaluation studies.
12. DA should receive additional budgetary support for testing and applying METRACAP.

6. Institutionalization

6.1 INTRAH

INTRAH has given considerable attention to developing an operationally useful definition of institutionalization. Its most recent articulation of the concept is "having in place an evolving training system that reliably anticipates and responds to, and interacts with, the service system in order for the service system to carry out its functions."² To verify the existence of institutionalization, the definition lists nine indicators, including existence of officially designated training teams performing according to performance standards in response to strategies and plans, curricula developed in accordance with service needs, follow-up, and ongoing monitoring and evaluation. INTRAH is guided by this definition in developing and implementing its training strategies and training plans.

As pointed out in the PAC IIa evaluation that dealt with INTRAH's work in Africa, given the reality of very weak ministries of health in that region, institutionalization might need to involve development of training systems that were not located solely within any existing organization. Rather, a range of relevant capabilities might need to be developed, which would be applied to strengthening the system with the expectation that over time, the system itself would be capable of assuming training responsibilities. As recommended in the PAC IIA evaluation report, INTRAH expanded the capacity of both regional offices, through staff additions, several in-country resident advisors, and a network of African consultants, permitting continuity and availability of assistance to institutionalize in-country training. Trainers have been selected and taught in teams. In Uganda, a back-up team has been prepared to be available when absences deplete the original group. These strategies have made it possible to proceed with planned training activities without interruption. While institutionalizing the development of teams of master trainers, in most countries in which it operates in Africa, INTRAH also considers that its main training locus is within the MOH although in every case this is a program unit rather than a training unit (see Appendix B).

Through these various efforts, INTRAH has helped increase the local capacity to carry out training in many of the countries in which it has worked. The USAID mission in Burkina Faso noted that the MOH's training capability has increased and, as a result of INTRAH's efforts in the provinces, a strong resource base has also been put into place at the local level. In Tanzania, where INTRAH has been working on in-service training in the MOH and with training staff of the Ministry's Family Planning Unit, the mission expects that the contractor's long-term advisor will aid in institutionalizing the unit's ability to coordinate the many training activities under its purview. REDSO commented that INTRAH uses an "empowerment approach" to training, which provides for the involvement of host country nationals during the entire process of design and implementation, and that INTRAH's training plans consistently include a plan for phasing out technical assistance.

6.2 Development Associates

DA's efforts to increase institutionalization of training capacity have been strong in a number of countries. In Guatemala, for example, mission staff commented that DA has met with success in this area in both the public and private sectors. In Ecuador, the institution assisted by DA is now able

²From a one-page memo entitled "INTRAH; Institutionalization of Training; Big Picture," dated October 28, 1992.

to maintain a training program on its own. According to the mission, the same holds true in India, where senior trainers from the Indian Medical Association are now carrying out the entire training effort, while DA has progressively reduced the level of its technical assistance. In the Philippines, USAID also indicated that the technical assistance provided by DA has been instrumental in strengthening the local institution's ability to plan, manage, and implement training programs. In Yemen, DA has developed a training strategy and plan with other agencies, which is expected to have a significant impact on training capacity and capability by virtue of its broad base in both pre-service and in-service training and the number of health manpower institutes involved. DA will apply its METRACAP instrument to assess the extent of institutionalization of training capability and capacity in institutions it has been assisting.

6.3 Conclusions and Prospects for the Future

Missions in all three regions provided positive feedback on the PAC contractors' achievements in increasing training capabilities and capacities within developing country institutions. Clearly, considerable progress has been made in strengthening institutional capacity, particularly through development of teams of master trainers.

At the same time, given the magnitude of the training task, the weaknesses of public sector institutions, and the scarcity of well-qualified personnel, it is not likely that technical assistance can be reduced significantly in the near future. Some missions indicated that additional technical assistance would be needed if institutionalization were to be achieved. In Peru, for example, mission staff indicated that technical assistance would be needed to reinforce pre-service training. Likewise, the Uganda mission noted that "significant progress" had been made in increasing capabilities in local institutions, but that, because the starting point was lower than in some other African countries, additional technical assistance would be required before training institutions were "fully capable."

To conclude, despite DA's and INTRAH's good work in the area of institutionalization, true institutionalization of any activity is dependent in part on the availability of local budgetary support. Given the large unmet need for family planning services that faces developing country family planning programs in all the regions in which the PAC project is active and given the severe lack of financial resources, especially for public sector programs, full institutionalization of family planning training, including adequate local budgetary support, clearly will not be achieved in the foreseeable future.

7. Other Impacts and Outcomes

7.1 Impact of Training

7.1.1 Family Planning Services

Evidence of Impact

INTRAH and DA have demonstrated at the micro level that their training activities have had a positive effect on acceptor rates, method mix, numbers of referrals, and provider skills and knowledge. In Africa, according to INTRAH's 1992 annual report, INTRAH's training activities have had both a quantitative and qualitative impact on family planning service delivery. In Uganda, for example, new acceptors more than doubled in two institutions in the period following provider training, and availability of family planning services has been extended to private sector clinics and maternity homes. At five sites in Togo, a marked increase in acceptors and continuing users occurred four months after training, while monthly averages of acceptors at five sites in Burkina Faso increased by up to 72 percent. Increases in both the number of service sites and the types of contraceptives available were also documented in Burkina Faso. Further, USAID mission staff in the latter two countries reported a substantial improvement in service quality. In Chogoria, Kenya, the supervisory training provided by INTRAH was found to have resulted in increased staff motivation and lower turnover and greater staff confidence in its family planning expertise. Also in Africa, USAID/Cameroon reported a doubling of contraceptive use and an increase in the availability of family planning services due to the training of additional service providers and the consequent establishment of an additional 12 facilities providing family planning services. In Botswana, the USAID mission indicated that INTRAH's activities have had a positive impact on service quality.

DA has also achieved some notable results. In the Philippines, referrals to clinic services by trained midwives have increased, and in Guatemala, 18 health NGOs are now incorporating family planning services into their health programs. As a result of DA's training of Indian Medical Association physicians in India, these physicians now prescribe oral contraceptives, and DA is collaborating with the Population Council on an impact evaluation of the Association's training. In Peru, USAID noted that DA's work with the Population Council and Pathfinder to improve training quality in contraceptive methodology and counseling is expected to be used to develop better approaches in future.

Measuring of Impact on Services

The contracts for PAC Iib do not include the requirement that the contractors assess the impact of training on service delivery. Following contract award, however, A.I.D. expressed great interest in this area and encouraged the CAs to gather and assess data and information to document service delivery impact. To their credit, and considering underfunding (see Section 8.5) and the requirement to perform contractually mandated activities, both INTRAH and DA have made considerable strides in this area. Moreover, in addition to their independent PAC Iib work, representatives of both CAs are members of A.I.D.'s Training Evaluation Sub-Committee of the Evaluation Working Group, which is studying how to define and measure training impact.

INTRAH has been especially responsive to A.I.D.'s request for information on the impact of its activities on service availability, accessibility, and utilization. According to its *1993 Progress Report and Workplan*, an INTRAH working group has expanded its list of service-related impact indicators and designed methods and instruments for systematizing the collection and reporting of impact data.

Ultimately, the impact of training upon a country's family planning services is difficult to assess and document at the macro level. Many other variables affect services including the presence, absence, and/or effectiveness of management, supervision, equipment, and supplies; country policies and reproductive health strategies; and the economy. Given these multiple factors, it is not possible to isolate the effect of training.

7.1.2 Supportive Environment

As noted above, a supportive, or enabling, environment for family planning training refers to that complex set of variables that work together to augment the productivity and quality of family planning trainees. Although the PAC IIb contracts do not call for the CAs to address efforts to this larger context, both institutions have explicitly worked to influence the environment for training. Not only have they capitalized on favorable environments where they exist; they have also worked to create them where they did not. In Uganda, for example, INTRAH addressed the problem of a weakened infrastructure by helping create guidelines and policies. In India, DA assisted the Indian Medical Association in the creation of an environment in which family planning services would be able to develop. Member physicians who developed full qualifications as trainers are now training as many other physicians as possible and are working with government family planning service providers at the government's request. In Bolivia, DA's vigorous involvement with host country staffs has helped convince them of the value of child spacing for maternal health. In short, the contractors' training efforts have had a multiplier effect in terms of the national receptivity toward family planning.

Another way in which contractors have worked to foster a supportive environment is to address medical barriers to service delivery. These barriers vary from region to region, and their negative impact depends, inter alia, on the stages of country and program development. In the LAC region, physicians themselves are often viewed as being the biggest barriers to the training of auxiliary personnel, whereas in India, the physicians are eager to set the standards for family planning delivery systems. In some LAC areas, feminists create major barriers in the acceptance of family planning.

INTRAH has data that show that it has made major progress in alleviating medical barriers in six African countries. Technical assistance has also been provided by the clinician consultants of both CAs on the issues of myths and false information, both of which require diligent attention in training programs. In the Dominican Republic, focus groups, consisting of both clients and service providers and conducted with DA assistance, determined that health care providers were often the source of widespread misinformation. Technical assistance was provided for directors and teachers from all three levels of nursing schools, and an important outcome of the workshop was the standardization of curricula for professional, technical, and auxiliary schools.

7.1.3 Policies and Norms

As part of their technical assistance in training, both CAs have done significant work in influencing policies, norms, and regulations with the objective of improving both quality and availability of family planning services. In the Dominican Republic, DA is providing technical assistance to establish national norms aimed at improving service quality. Because national norms did not address the role

of nurses in family planning services, DA sponsored a national workshop to define specific job responsibilities for each cadre of service provider, including nurses. Representatives from the government, family planning service providers, nursing schools, and nursing associations developed descriptions of job responsibilities and recommendations for policy changes.

INTRAH has provided technical assistance to several countries in formulating or revising family planning policies and norms. In Uganda, in part as a result of INTRAH assistance, Depo-Provera acceptors increased dramatically (0 to 84 and 0 to 384) in two hospitals over a 12-month period following a policy change in eligibility. A policy change in Togo has resulted in adolescent acceptors of oral contraceptives at two hospitals that previously had no such acceptors. In Cameroon, INTRAH-assisted policy development efforts have had a major impact on family planning services and providers. On the other hand, as a result of reduced project funding and instructions from A.I.D., INTRAH has not been able to provide support to African professional associations and advisory groups for meetings and related activities, as it had in the earlier project. The result has been that opportunities have been missed for influencing policies related to family planning.

With regard to DA, in the ANENA region, the USAID mission in India anticipates that a dialogue with the MOH will be initiated following the completion of training cycles, possibly resulting in policy changes relating to the promotion of oral contraceptives. In Yemen, the mission reported that quality of family planning/MCH services will be improved as a result of the development of protocols and regulatory practices. Within LAC, the mission in the Dominican Republic confirmed that DA had achieved considerable success in assisting host country institutions to establish and adopt national norms defining the roles and responsibilities of nurses in family planning. Likewise, in Ecuador, DA assisted in the development of norms and regulations relating to IUD insertions by medical personnel. In Bolivia, DA has also provided substantial technical assistance. After national norms for reproductive health were revised in 1992, a national reproductive health training committee, with DA technical assistance, began to review training plans to ensure that they were in accord with revised norms.

Recommendation

13. Modest project funding should be made available to enable the CAs to provide occasional support to professional associations (e.g., nursing councils) for meetings and related activities that might result in policies, norms, etc. that would enable these providers to offer higher-quality and more easily available family planning services.

7.2 Project Outputs

At approximately two-thirds of the way through their respective contracts, INTRAH and DA have made considerable progress in achieving their target outputs (see Tables 1 and 2 below). INTRAH has already met its requirement to provide assistance in 18 countries, and DA is only two countries short of its 20 country requirement (10 per region — although, due to funding shortages, it does not anticipate extending activities into any more countries). With respect to provision of support to in-country institutions, DA has fully achieved its contract requirements of 32 LAC institutions and 18 institutions in the ANENA region. As a result of A.I.D.'s Priority Country Strategy and the consequent reduction in the number of assistable countries, INTRAH lags somewhat behind DA in this area, to date having provided support to 22 of the 36 institutions specified in its contract. This

represents achievement at a 60 percent level, and INTRAH fully expects to meet or exceed the requirement by the conclusion of the contract period.

With respect to support to third country/regional institutions, DA has fallen short of its requirements whereas INTRAH has met its much lower target. Against a contractual goal of providing support to a total of 17 third country institutions, DA has assisted 1 institution in the ANENA region and 2 in LAC. This stems largely from reasons already signaled in the evaluation of PAC IIa, including excessive cost, difficulty in identifying or establishing "culturally acceptable" training environments, and the reluctance of some institutions to accept PAC assistance. In addition, DA staff make the very valid point that development of additional regional/third country training capabilities is not an appropriate mechanism for achieving the principal PAC IIb goal of institutionalizing training capability in each country. As a result, DA and A.I.D. have discussed modifying the requirement to two institutions in LAC and two in ANENA. INTRAH, which works only in Africa where it is expected provide assistance to far fewer institutions, has already met its requirements to support 5 third country institutions. (See Table 1.)

Table 1
Number of Countries and Institutions Receiving Support
(as of March 1993)

	Countries		In-Country Institutions		3rd Country Institutions ¹	
	Planned	Actual	Planned	Actual	Planned	Actual
DA (total)	20	18	50	50	17	3
LAC	10	9	32	32	6	2
ANENA	10	9	18	18	11	1
INTRAH	18	18	36	22	5	5

Source: DA and INTRAH

¹Contract assumes that most 3rd country/regional institutions are also considered in-country institutions.

INTRAH has already substantially exceeded its requirements for numbers of participants to be trained. DA, on the other hand, had trained about 50 percent of its target at the time of the evaluation, although it also expects to exceed its goals by the end of the contract. To do so despite a shortage of funds, it plans to reduce the number of first generation trainees and to increase the number of second generation trainees commensurately (second generation trainees are trained without cost to the project — see below). By the end of the contract, DA anticipates training a total of 80,850 individuals, against a goal of 75,545 trained participants. (See Table 2 on the next page.)

With respect to U.S. participant training, in view of a general recognition that in-country training is normally more suitable for PAC workers, both CAs have fallen well short of their targets. INTRAH and DA have provided such training to only 2 and 12 participants respectively, whereas their contracts call for 15 participants from Africa and 20 from LAC and 25 from ANENA. It is probable that both CAs will request formal contract modifications to reduce these targets.

In sum, in the face of severe budgetary constraints and the unforeseen changes stemming from A.I.D.'s Priority Country Strategy (see Section 8.2.2), both CAs are to be commended for their progress toward achieving and/or exceeding contract outputs which are critical to project success.

Table 2
Number of Participants Trained (First and Second Generation)
(as of March 1993)

	In-Country		3rd Country		U.S.	
	Planned (LOP)	Actual	Planned (LOP)	Actual	Planned (LOP)	Actual
DA (total)	75,000	36,965	500	159	45	12
LAC	55,000	31,624	250	139	20	12
ANENA	20,000	5,341	250	20	25	0
INTRAH	20,000	24,000	225	300	15	2

Source: DA and INTRAH

Tables 3 and 4 below and on the following page contain selected country examples of training multiplier effects as prepared by each contractor in terms of numbers of second generation trainees. These are those who are trained by PAC IIb-trained participants, independent of the contractor's technical, training, and financial inputs. These data clearly demonstrate that the training of small numbers of trained trainers (senior trainers, provincial trainers, service provider-preceptors) can result in subsequent training of substantial numbers of service providers without other inputs from the contractors. The development of these trained trainers has also brought about a substantial increase in training capabilities on the part of CA-assisted institutions.

Table 3
DA: Multiplier Effect of TOT¹

	Senior Trainers	2nd Generation Trainers	1993 FP Workers	Cumulative 1993-97 Trained (Anticipated)
India	9	61	1,670	8,350
Guatemala	28	100	9,500	47,500

Source: DA

¹This table is illustrative of the multiplier effect of DA training in other settings.

Table 4

**Training Multiplier Effects:
INTRAH Second Generation Trainees by Type of Training**

Country	Type/Date of Training	Number and Type of First Generation Trainees Followed Up	Number of Second Generation Trainees Produced	First/Second Generation Trainee Ratio
Burkina Faso	TOT April 1990	13 PST & IST National Trainers	586 in two years	1:45
Burkina Faso	TOT February 1992	10 Provincial Trainers	101 in nine months	1:10
Burkina Faso	Clinical FP Preceptors' Skills May 1992	9 FP Service Providers	88 in nine months	1:10
Cameroon	Clinical FP Preceptors' Skills November 1991	5 FP Service Providers	52 in nine months	1:10
Uganda	FP/MH Clinical Update and Preceptors' Skills August 1991	11 FP Service Providers	205 in seven months	1:18
Togo	Clinical FP Preceptors' Skills October 1991	7 FP Service Providers	100 in thirteen months	1:14

Source: INTRAH

8. Management and Funding

8.1 Headquarters, Regional Offices, and Regional Advisors

8.1.1 Structure

Both INTRAH and DA have regional offices that manage project activities at the field level. INTRAH has two regional offices: an office in Nairobi, Kenya, for its eastern and southern African operations and an office in Lome, Togo, to oversee its West Africa activities. DA has one regional office: in Istanbul, Turkey, which oversees its operations in the Near East and North Africa. DA manages its operations in Latin America and Asia from headquarters. In addition, INTRAH has resident advisors in Tanzania, Uganda, Togo, and Burkina Faso, countries in which it has a major responsibility for helping to develop training capacity and capability. DA has no resident advisors.

Based on a review of DA's plans for training activities in Turkey and the region, its regional office seems to provide an effective way of managing project activities in that area.

The evaluation report on PAC IIa recommended that INTRAH headquarters delegate increased responsibility and authority to its regional offices. INTRAH's regional offices have been effective and INTRAH's having full-time staff in Africa has helped to compensate for weak structures in the health sector. The Nairobi regional office appears to be somewhat understaffed, however, not only in view of the wide range of training activities under way in four East and Southern Africa project countries but also in light of new opportunities that may be opening up in other countries of the region, including Ethiopia and Zimbabwe. The office currently lacks full-time persons assigned to two key areas of training — development of training materials and evaluation — and lack of funding has made it impossible to fill these slots. Rather, each area is handled on a part-time basis by staff along with other responsibilities. In addition, INTRAH headquarters appears to be giving inadequate strategic guidance and support to the Nairobi office, particularly at a time when roles of respective CAs working in the region are being assessed and determined by USAID missions.

The use of resident advisors in four of its major countries of emphasis has meant that INTRAH assistance can be comprehensive and can have continuity. This is especially important when infrastructures have been weakened or are in elementary stages of development. The advisors for Uganda and Tanzania, functioning as experts and role models, have played major roles in expanding the family planning capability of these countries and have provided supervision and management assistance to fledgling staff.

8.1.2 Assessment of Staffing

Headquarters and regional staff of both CAs are well qualified and have a wealth of experience and an appropriate range of skills in training. All the USAID missions queried provided very favorable assessments of the efficiency and effectiveness of the PAC contractors' regional office project management and technical assistance and the appropriateness and relevance of staff skills and experience.

Missions were also positive with regard to the performance of contractors' staff in field situations, whether they were headquarters staff, consultants, or regional office staff. In the LAC region, for

example, where DA provides technical assistance either through headquarters staff or through consultants, USAID missions in Guatemala, Ecuador, Peru, and Nicaragua indicated that these individuals have performed well, that technical assistance has been timely, and that contractor performance is satisfactory. In the Philippines and India, USAID missions also commented favorably on the technical assistance provided by DA headquarters staff and consultants. In the North Africa and Near East regions, missions in Tunisia and Yemen praised the effectiveness, competence, and skills of DA's regional office staff. In particular, the USAID mission in Tunisia drew attention to "the excellent human qualities" of the DA staff which, it said, contributed to a good working relationship between USAID and the host country training institution.

Similar comments were made with respect to INTRAH's performance. USAID missions in Rwanda and Togo remarked on the effectiveness, competence, professionalism, and skills exhibited by INTRAH personnel, and the mission in Burkina Faso commented on the high quality of technical assistance and valuable management support. In Cameroon, USAID also commented on the timeliness and quality assistance that had been provided. The mission in Uganda praised both the resident advisor for contributions to the "successful completion of activities" and the regional office staff for its careful monitoring and "excellent support." USAID/Tanzania and REDSO were similarly very positive. REDSO noted that ". . . the skills mix is right and staff work extremely well together . . . conduct themselves in a highly professional manner [and that] host country nationals have repeatedly commended their performance in the field."

8.1.3 Project Documentation

INTRAH appears to have a well-organized filing system, with the ability to quickly retrieve documents and compile appropriate data and information. DA's project database is similarly impressive and is designed to provide rapid retrieval of data and information on project events, subprojects, trainees, trainers, countries, materials, and other critical elements.

Recommendations

14. **A.I.D. should increase INTRAH's funding to permit hiring of additional professional staff for the Nairobi regional office.**

15. **The INTRAH director should give more strategic guidance and support to the Nairobi regional office.**

8.2 A.I.D.

8.2.1 Oversight

Senior staff of both CAs have indicated that A.I.D.'s tendencies to participate in day-to-day management of project activities and to make frequent requests for information has at least three consequences: (1) CA staff time is reduced for the professional activities for which they were contracted (which creates pressures to increase staff numbers); (2) project work and new project opportunities get inadequate attention; and (3) the disproportionate (and inappropriate) amount of time spent by professional staff on paperwork has a negative effect on staff morale.

Recommendations

16. **The Office of Population should make a serious effort to reduce the amount and frequency of requests for information from the CAs.**

17. **The Office of Population should be less involved in day-to-day management of CA project activity.**

8.2.2 Priority Country Strategy

A.I.D.'s major policy shift in 1991 that called for focusing on the larger countries within each region has had a disruptive effect on both PAC IIb contractors. This "Priority Country Strategy," as it is now called, was designed to provide a more focused approach to assistance efforts by concentrating activities in countries with large populations. Neither INTRAH nor DA was given advance warning of this critical change in strategy, and A.I.D. was perceived to be markedly reticent in communicating information and details to both CAs.

From a practical standpoint, the new strategy means that CAs have been instructed to direct central funds to funding activities in priority countries and to use USAID mission buy-ins from bilateral projects for activities in non-priority countries. The Office of Population anticipates that the policy will be phased in gradually without disrupting activities or commitments that were in place when the policy was initiated.

This policy shift has created considerable disruption and uncertainty on the part of both CAs with respect to their current and, more particularly, their planned activities in each region. The strategy has resulted in many CAs', including DA and INTRAH, seeking opportunities for project activities in the priority countries. In some instances, the PAC contractors believe that they have been blocked from working in certain priority countries because missions wanted to reduce the number of CAs working in the country, i.e., in order to reduce the mission management burden and to reduce the number of CAs from which client institutions, such as ministries of health and NGOs, receive technical and other assistance. This sometimes has meant that the mission has sought multi-purpose CAs in preference to single-purpose CAs such as the PAC contractors. In the case of DA, the result has been that, although it is working in six priority countries, it has not been able to work in six others, namely, Bangladesh, Egypt, Indonesia, Morocco, Nepal, and Pakistan. Because most of its programs were initiated before the Priority Country Strategy was put in place, however, DA is still using central funds in virtually every country in which it works. (See Appendix D.)

Other problems have arisen in non-priority countries with bilateral agreements. For example, the scope and duration of these agreements do not necessarily coincide with DA's and INTRAH's contracts. The mission in Botswana (which has a bilateral but is not a priority country) expressed doubt about whether the project could continue to be responsive due to the new strategy. In some non-priority countries, the contractors may be placed in the uncomfortable position of "abandoning" these countries.

The policy shift, with its requirement to replan strategies and reprogram activities, has placed an additional and unforeseen administrative burden upon both CAs, taking valuable time away from the performance of technical services and creating some delays in contract performance. Both INTRAH and DA are to be commended for their ability to maintain flexibility, readjust priorities, and continue high levels of performance despite these impediments.

Recommendations

18. A.I.D. needs to communicate with its CAs when major policy changes are being considered and before the policies become effective. Although the CAs are not expected to influence such policy decisions, the provision of advance information will aid CAs in planning and decision-making.

19. When policy changes such as establishment of priority countries are being considered, A.I.D. should ensure that all significant implications for CAs are taken into account.

8.2.3 Family Planning, Family Health, and AIDS/Sexually Transmitted Diseases

A.I.D.'s existing organization, which has separate offices for health and for population and separate CAs for each of these areas, sometimes makes it difficult to provide integrated technical and other assistance to host country institutions that have established as a priority the development of "family health" services, which encompass both MCH and family planning. This is particularly true of ministries of health although it applies to some NGOs as well. PROSALUD in Bolivia has found that whereas some women will not avail themselves of family planning services that stand apart, they are eager to participate when family planning is offered in the context of family health. At CIES, the focus is on women's health, empowerment, and family planning.

Both contractors include some training in AIDS and sexually transmitted diseases (STD) as part of clinical training. Given the epidemic proportions and the dangers of AIDS to both family planning clients and service providers, technical assistance related to training in family planning should always include appropriate training in AIDS/STDs.

Recommendations

20. A.I.D. should explore ways to integrate more effectively its work in MCH and family planning, particularly when providing support to ministries of health and other organizations that promote integrated MCH/family planning services.

21. Given the potential risks related to AIDS/STDs to both family planning clients and service providers, both contractors should ensure that in providing technical assistance in family planning training, adequate attention is given to AIDS/STDs.

8.3 Subcontractors

In its original proposal to A.I.D., INTRAH proposed to utilize two U.S.-based subcontractors — Training Resources Group, Inc. (TRG) and the Western Consortium — to carry out various training workshops. INTRAH, however, has made little use of these groups, preferring whenever possible to develop and use persons from the region to carry out training activities. Although it is understandable that the subcontractors are not pleased with INTRAH's actions, the latter's strategy offers a greater potential for continuity of assistance to organizations and is, in fact, a form of regional capability building. Nevertheless, such actions on the part of prime contractors are unfair to proposed subcontractors, which often assist in proposal preparation and have an expectation that pre-award commitments and agreements will be honored.

DA, on the other hand, proposed and is actively using the services of Pathfinder International, which has provided qualified personnel to staff the ANENA regional office. DA is particularly pleased with the Pathfinder regional office director's ability to develop and solidify relationships in the countries in which the PAC project is working. DA monitors the Pathfinder subcontract closely, conducts periodic planning sessions with the regional director, and maintains frequent contact and communications with Pathfinder.

Recommendation

22. A.I.D. should encourage CAs to utilize their proposed subcontractors. At the same time, INTRAH's development and use of persons from the region (rather than the subcontractors) has proved to be a sound strategy.

8.4 External Relationships

8.4.1 Overall Performance

Communication

PAC contractors have maintained open and effective communication channels with their various constituencies — with missions, A.I.D., regional offices, and host countries. USAID missions in the Dominican Republic, Ecuador, Guatemala, Peru, India, the Philippines, and Yemen reported on DA's ability to relate to these various groups. INTRAH's performance in Africa was also found to be very satisfactory. The mission in Tanzania described such communications as "excellent," and missions in Burkina Faso, Togo, Cameroon, and Uganda also responded favorably.

Several missions commented particularly on the CAs' abilities to facilitate and/or establish communications and relationships with host country institutions. In Bolivia, DA-assisted institutions were unanimous in their praise of the way in which the contractor kept in touch and the skills and strengths it exhibited. One problem area in communications is the occasional conflicting signals that the CAs receive from the Office of Population and USAID missions.

Coordination and Collaboration

Both DA and INTRAH have done an excellent job in collaborating and coordinating with other Office of Population CAs, other donor agencies, and USAID missions. Their willingness to participate in joint efforts and, in many instances, to take the lead role in organizing collaborative activities, has been praised both by other CAs and by PAC country missions.

Included among the projects, organizations, and agencies with which the PAC contractors have worked closely are the Family Planning Services Expansion and Technical Support (SEATS) project, the Population Council, World Neighbors, Pathfinder International, JHPIEGO, PCS, FPMD, AVSC, the Social Marketing for Change (SOMARC) project, CARE, UNFPA, the World Bank, and the International Planned Parenthood Federation (IPPF). These organizations have responsibility in such areas as contraceptive supplies, management information systems, supervision, etc. — all factors that affect the effectiveness of training. DA's collaborative approach in both the LAC and ANENA regions is viewed very favorably by a number of missions, including those in Bolivia, Guatemala, Dominican Republic, Nicaragua, Ecuador, Peru, and the Philippines, India, and Yemen. Moreover,

A.I.D. has asked DA to establish a coordinating entity in Peru to facilitate collaboration among the various CAs working in that country.

INTRAH, likewise, received high marks from USAID mission staff for its collaborative approach. Missions in Cameroon, Tanzania, Uganda, Rwanda, Burkina Faso, and Togo were particularly appreciative of INTRAH's interested and vigorous approach to working with others.

8.4.2 Responsiveness to USAID Mission Needs

Most USAID missions indicated a high degree of satisfaction with PAC contractors' responsiveness to their needs. In Cameroon, for example, the mission found INTRAH "the most effective" Office of Population CA working in Cameroon. Other missions in the region used phrases such as "very effective" (Burkina Faso), and "very/absolutely responsive" (REDSO, Tanzania) to describe INTRAH.

In the ANENA and LAC regions, USAID/India indicated that DA has been "very responsive" and the Guatemala mission indicated that "almost everything requested" [of DA] had been provided. In Ecuador, USAID commented that DA has been particularly responsive with respect to CBD training activities. In Peru, the mission noted that although assistance was on occasion offered by DA prior to consultation with USAID, the coordinating entity to be established by DA in Peru should improve planning and hence avoid a repetition of this problem.

8.4.3 Overlapping CA Mandates

Both DA and INTRAH are aware of the considerable overlap of their mandate with that of other CAs that have a training mandate or project training component (e.g., JHPIEGO, SEATS). Both have also been effective in resolving issues that have arisen in this regard within particular countries. (For example, in recognition of INTRAH's positive approach in this regard, SEATS has requested INTRAH assistance with its training component in Cameroon.) Clarification and resolution of boundaries and overlapping activities appear to be most successful when carried out at the country level via meetings and discussions between the PAC contractors and the other CAs involved in such activities.

Resolution of overlapping mandates may become more difficult and time-consuming when A.I.D. or USAID missions dictate which CA should carry out a particular activity. In Brazil, for example, USAID requested that JHPIEGO provide training that clearly fell within the PAC IIb mandate. Although both JHPIEGO and DA questioned this decision and requested DA involvement, USAID remained firm regarding use of JHPIEGO.

Both INTRAH and DA have also made sincere attempts to coordinate with other CAs with regard to supervision and other systems that support their training activities. They regularly engage in pre-planning activities with these organizations and consult and coordinate with other appropriate groups to address gaps and needs. Supervision, supplies, and management information systems are mentioned by both CAs as areas requiring more attention. The PAC contractors have also been conscientious about sharing information and materials with other CAs and donor agencies.

8.4.4 Relations between the Two PAC Contractors

The two PAC contractors collaborate, coordinate, and share information less with one another than they do with other organizations. Although on some occasions, the two CAs have come together to

consult on various issues, such discussions more often take place in the context of larger meetings such as Office of Population Task Force or Committee meetings involving many CAs.

Recommendations

23. The Office of Population should ensure mission understanding of the roles and mandates of all CAs involved in training activities.

24. The Office of Population should require the PAC IIb contractors to exchange information and share results and lessons learned.

8.5 Funding

All parties (A.I.D., DA, and INTRAH) agree that underfunding of both CAs has been a significant and continuing problem. Underfunding has meant that both CAs have been receiving about 65 to 70 percent of planned budgets. To its credit, A.I.D. has been understanding and supportive.

The funding problems continued even during the course of this evaluation, with DA having been informed at the end of February 1993 that only \$500,000 would be made available to it this year. Only one month earlier, DA had been told that it would receive between \$2 and \$2.5 million. This in turn was half of the budget that was projected and submitted to A.I.D. in the fall of 1992.

Although A.I.D. is aware of some of the limitations that underfunding has imposed upon the CAs, it may not recognize the full impact. Underfunding has had both programmatic and administrative consequences. Specifically,

Programmatic

- Underfunding has limited programmatic activities of both CAs. Many examples of the effects of funding shortages have been detailed above. DA anticipates reducing its country targets and has cut back on anticipated numbers of first generation trainees, although not the total number of trainees. INTRAH has been able to carry out its contract scope of work but would be able to do more in all areas if the requisite monies were made available. In addition, both contractors have been unable to respond to all requests for pre-service training; INTRAH has been unable to hold meetings for African professional associations and advisory groups or to fill slots in its Nairobi regional office; and DA could undertake additional evaluation studies with increased funding.

Administrative

- A significant burden has been placed on all project staff. They are caught in an endless cycle of replanning, reproposing, rebudgeting, and reacting. This represents a substantial drain on technical resources and creates excessive paperwork.
- The CAs' manpower is stretched to the limit. INTRAH, in particular, has not filled some vacant positions and has had to use staff instead of consultants to fulfill certain technical requirements.

- CAs operate in an atmosphere of tension, as they do not know from one day to the next whether or how much money will be made available. This has resulted in an aura of uncertainty about employment, the future of the project and the organization's activities, and the ability to fulfill contract requirements.
- CAs cannot operate according to long-term planning horizons, a serious omission given the strong focus on institutionalizing training capability.

Funding the project fully would not only eliminate these problems; since infrastructures are already in place, a high proportion of any additional funding would go for program activities in host country institutions.

Recommendations

25. **Actual funding levels should be close to planned funding levels.**
26. **A.L.D. should try to provide more stability in project funding.**

9. Design of Future Project

9.1 Overall Conclusion

PAC IIb has been an effective mechanism for developing the capacity and capability of training institutions to produce more and better trained family planning service providers and thus increase the quality and quantity of family planning services. Given the project's effectiveness and given that the service providers assisted through the PAC IIb project are a key element of most family planning programs in all regions, a continuation of the project is clearly warranted.

9.2 Issues to be Addressed

9.2.1 Overall Project Design

One or More Contractors

This evaluation confirms the conclusion of the PAC IIa evaluation: that the use of more than one CA to implement PAC training activities offers several important advantages. Among them are the following:

- the diversity of the regions in which PAC training is required;
- the importance of capitalizing on the rich experience that the CAs have acquired through years of work in several of the regions;
- the benefits of competition in almost any area of endeavor; and
- the usefulness of having more than one organization seek ways to improve training in order to improve the quality and quantity of family planning services (each organization bringing its own experience to bear and using a somewhat different perspective).

Inclusion of Public, Private, and NGO Sectors

With respect to sectors that should be included in the next PAC project (i.e., public, NGO, private), the flexibility of the current project allows the contractors to respond to opportunities and needs as they are identified. Decisions regarding sectors to be assisted in the next project should be based on the needs of the country in question and the relative current and potential importance of the sectors. (This underscores the importance of developing country strategies and undertaking needs assessments.)

Project Purpose

The next project should continue to emphasize institution building. In addition, it should stress the importance of influencing the environment for training through such activities as collaboration with professional associations that have influence over family planning policies, regulations and norms.

9.2.2 Implementation of Training

Priority Training Areas

It may not be possible between now and the end of the contract to appreciably increase emphasis on the relatively neglected areas of training noted in Recommendations 3 through 7. On the other hand, with added funding and more time for planning, significant progress could be made in the next project in all these areas. All deserve increased attention in view of their relevance to improved and expanded family planning services.

Inclusion of AIDS/STDs and Other Health Issues in Family Planning Training

Short of major policy decisions affecting the organization of USAID (which currently separates support for family planning training from support for family planning services delivery), the current scope of the PAC IIb project is generally appropriate. It would be useful, however, if USAID could explore ways of providing more integrated assistance in training (i.e., not just family planning) where the client organizations have a family health focus. This is particularly the case in most ministries of health but is also true of some NGOs. Given the prevalence of AIDS/STDs and the potential dangers to both clients and service providers, training should address this issue also.

9.2.3 Methodologies and Materials

Materials Database

The training materials database should be included in the next project. Its character and scope should be determined on the basis of DA's current evaluation; the recommended testing of an expanded distribution to a sample of host country institutions; and a careful assessment of the financial and other resource requirements of such an expanded distribution.

9.2.4 Evaluation

The follow-on project should provide increased support for evaluation. Not only is this activity important; increased efforts would take advantage of the excellent practical capability that the two CAs have developed in this area. The efforts DA has made to collaborate with the Population Council in the area of operations research are to be commended (see Section 7.1.1). Such efforts cannot, however, be a substitute for an in-house evaluation capability that is applied to all program activities in which the CAs are engaged.

9.3 Management

Location of Headquarters

CA headquarters need not be located in the Washington area. The array of communications media available today make this unnecessary. Further, there may be disadvantages to locating in the Washington area in that proximity may encourage Office of Population involvement in day-to-day management of the CAs' work.

Regional Offices

Regional offices are clearly very effective in the current project. Decisions about such offices in a future project should be based on an analysis of various factors including volume of project activity in a region, assessment of the infrastructures of client institutions in a region, and a determination of the need for a CA regional presence to achieve project objectives.

A.I.D. Coordination of CA Work

The Priority Country Strategy is placing serious constraints on PAC IIb in a number of countries (see Section 8.2.2), the result in some cases of USAID missions' not being well informed as to the scope and competencies of the PAC CAs, in particular their skills in needs assessment and strategy development. Asking CAs to become involved in project execution after planning is complete can diminish their contributions.

Cooperation and Collaboration

For training to be effective, as measured in terms of improved quality and quantity of family planning services, other essential elements, such as supplies, supervision, information systems, etc., must also be present. This means that the PAC CAs should be encouraged by USAID missions and by A.I.D. to continue to coordinate and collaborate with other CAs in an effort to ensure that all these essential elements are present.

Funding

Given that both CAs have been unable to respond to all requests for assistance, a follow-on project should be designed to ensure that actual funding is closer to planned funding. Consideration should also be given to increasing the level of planned funding in order to take advantage of opportunities to use the significant capabilities that the CAs have developed. Because the Priority Country Strategy may limit the ability of the PAC CAs to pursue useful work in non-priority countries, consideration should be given to making available a moderate proportion (perhaps 15 percent) of central funding for use in such countries.

Logistics Support

Several instances were cited in the course of the evaluation of trainees who had returned to their working sites after training, only to have been unable to practice their newly learned skills due to lack of contraceptives or medical supplies. The result can be that some of these skills may be forgotten and the benefits of the training lost. Eleven of the fourteen missions responding to the questionnaire for this evaluation strongly supported the suggestion that the training CAs be authorized to provide essential medical equipment and other supplies, including contraceptives where necessary, to ensure that trainees have the requisite elements to put into practice what they have learned. Training CAs should not, however, become a continuing source of contraceptives and medical supplies.

Recommendations

1. **A.L.D. should continue its efforts to train PAC workers by authorizing a follow-on project focused on training this important group of family planning providers.³**
2. **Given 1) the diversity of the regions in which PAC training is required, 2) the depth of knowledge and experience the current CAs have in several regions, and 3) the advantages of competition, and 4) the usefulness of having more than one organization seek ways to improve training, A.L.D. should continue to use more than one CA in the next project.**
3. **The breadth of mandate for the next project should closely resemble that of the current one. It should explicitly emphasize not only institution building but also influencing the environment for training, through, for example, collaboration with professional associations.**
4. **Regarding sectors (public, NGO, private) for PAC attention, the next project should continue the flexibility of the current one. Decisions regarding sectors should be based on analyses of country situations.**
5. Priority training areas should include how best to provide family planning services to adolescents and to men; continued attention to supervision, incorporating where feasible the concept of team training; use of clinic data by service providers and their supervisors for planning and management; exploration of the need for refresher training.
6. **Efforts should be made to provide integrated (not just family planning) technical assistance in training to those client institutions that focus on family health or MCH/family planning care. Given the prevalence and danger of AIDS/STDs to both clients and providers, training should address this area also.**
7. The training materials database should be included in the next project. Resource requirements should be carefully assessed before distribution is expanded on other than a pilot scale.
8. Support for evaluation should be increased both because it is important and because the capability that the CAs have developed in this area should be utilized.
9. The CAs should not be required to have headquarters in the Washington area.
10. Decisions about regional offices in the next project should be based on analyses of the need for same.
11. **USAID missions should be given information on a regular basis as to scope and competencies of the PAC CAs and should be encouraged to include the CAs in needs assessments and planning if the latter are to be involved in project execution.**

³Recommendations or parts of recommendations that appear in boldface type are included in the Executive Summary as the principal recommendations for a future project.

12. Funding for the next PAC project should be increased. Further, actual funding should be close to planned funding. A moderate proportion of central funds (perhaps 15 percent) should be available for use in non-priority countries.

13. The project CAs should be encouraged to continue their collaboration with other CAs in an effort to ensure that all necessary elements (supplies, management information systems, supervision, etc.) for effective family planning services are present.

14. The CAs should provide essential medical equipment and supplies, including contraceptives, to ensure that, following completion of training, trainees have the requisite elements to put into practice what they have learned. PAC CAs should not become a continuing source of such supplies.

Appendices

Appendix A

Description of Evaluation

The evaluation team consisted of Robert Wickham, team leader and consultant in management and institutional development; Karen Berney, consultant in community health; Deborah Kluge, consultant in management; and Charlotte Quimby, nurse-midwife and women's health consultant. The evaluation was arranged through the Population Technical Assistance Project (POPTECH).

The purpose of the evaluation was to (1) document the progress made worldwide in the development of PAC IIb assisted agencies and institutions in their ability to institutionalize pre-service and in-service family planning training and education programs; (2) review the achievement of project objectives; (3) identify needs; (4) provide recommendations regarding a follow-on project (see Attachment 1).

The methodology consisted of review of A.I.D. and Cooperating Agency (CA) documents (see Attachment 2), briefings by A.I.D. Office of Population staff, meetings with staff of both CAs at their headquarters, meetings with USAID mission staff in La Paz, Nairobi and Yaounde and with representatives of other CAs and donor agencies, a visit to INTRAH's regional office in Nairobi, visits to project sites in Bolivia, Cameroon and Kenya, and meetings with INTRAH resident advisors and project staff from Uganda and Tanzania and the West Africa Regional Office (see Attachment 3). The team also undertook an intensive review of DA's training activities in three countries (Bolivia, Peru and Philippines) with relevant DA headquarters staff in Arlington. In addition to the materials listed in the bibliography, the team reviewed the Tanzania and Uganda service policies, standards and service protocols (as well as those from francophone countries); the Uganda Nurse Aides Guide; PAC IIb semi-annual reports one through six; and country training proposals, strategies, subcontracts and budgets for seven subprojects. The evaluation team had inadequate time for initial review of documents before briefings with Population Office staff and before meetings with staff of the two CAs.

As part of the preparation for the evaluation, the Office of Population's Division of Information and Training (IT) requested responses from 14 missions to a set of questions regarding the project (see Attachment 4).

Recommendation

POPTECH and A.I.D. should plan evaluation schedules in such a way that team members have an opportunity to read at least all key documents prior to initial briefings.

Attachment 1

Scope of Work

PAC IIb Project #936-3031

The evaluation team will: 1) document the progress made worldwide in the development of PAC IIb assisted agencies and institutions in their ability to institutionalize family planning training and education programs (pre and in-service); 2) review the achievement of project objectives; 3) identify gaps under PAC IIb; 4) provide recommendations that will assist AID/W in the development of a follow-on project to be designed in FY 1993 and approved and obligated in FY 1994.

The team will examine the major components of the project by addressing the questions (sections A-H below). In a final report the evaluators will provide their findings, conclusions and recommendations. The final report should integrate the findings of the team obtained from all sources, citing differences in outcome by contractor if appropriate. Findings should be displayed in tabulated form whenever possible.

A. Project Strategies, Assessments and Training Plans

1. Are training plans and activities based on a national comprehensive strategy?
2. Is this strategy based on the needs and resources of the country being assessed? Is it linked to service delivery goals? Is it linked to the activities of other CAs?
3. What has been the impact of the contractor's country strategies on the availability of family planning training and service delivery?

B. Implementation of Strategies, Needs Assessments, and Training Plans

Training Activities:

1. What, in the team's view, is the level of quality of the training?
2. Are the appropriate cadre of workers selected for maximum impact? Are they trained in the appropriate skills and relevant courses?
3. What follow-up is provided after training? Is it sufficient?
4. Have guidelines and protocols been developed for different cadres of workers and for clinical and training skills? Are they being used when trainees move into service provider roles?
5. Address collaboration and coordination with other agencies and whether these efforts need to be improved.

C. Evaluation

1. Have appropriate indicators been used to evaluate the effectiveness of training and its impact on service delivery?
2. How have the results of these evaluations been used to adjust training activities, training plans and strategies?

D. Training Methodologies, Models, and Materials

1. Are the training methodologies innovative and appropriate for the topics, level of workers and geographic area?
2. What mix of training models and teaching methods does the contractor use? Is there a sound rationale for their use?
3. Do the contractors produce materials that are field tested, used and not duplicative?
4. What efforts have been made to promote capability for local production of materials or greater access to existing materials?

E. Institutionalization

1. How effective have the contractors been in increasing the training capabilities and capacity of developing country institutions and agencies in in-service and pre-service programs? For example, have the assisted institutions and agencies been able to maintain training programs with decreased technical assistance?
2. Has family planning been integrated into the curricula and included in national qualifying exams?
3. What efforts have been made to develop systems (for in-country use) to: track and locate trainees, conduct evaluations, develop materials etc.?

F. Other Impact and Outcomes

1. What contract outputs have been achieved? How is the project performing on actual versus planned activities?
2. What evidence is there of the multiplier effect of training trainers?
3. What influence has the PAC IIb had on FP service delivery, guidelines, policy and regulatory practices?

G. Management Structure and Process

1. Are headquarters and regional offices providing efficient and effective project management? Do offices have adequate numbers of staff with the right skills mix and relevant experience?
2. What impact have resident advisors (other than regional office staff) and use of host country personnel had on the work load and implementation plan?
3. Are subcontractors being used effectively?
4. Is communication between the contractors, missions, AID/W, regional offices and host countries satisfactory?
5. Has the project been responsive to mission's needs?

H. Generic Questions

1. How can AID/W improve the project design?
 - a. Should the follow-on project's headquarters be located in Washington D.C.? Why or why not?
 - b. Comment on the value of regional offices; where should they be located?
 - c. Does the project need to place more emphasis (or less) on any of the sectors, i.e. public, private, informal?
2. Policy reforms, educational reforms, measures to ensure contraceptive supply, and national guidelines for training and service delivery tend to create a "supportive environment" for family planning. Has PAC IIB's effectiveness been increased where these conditions exist or hampered where they don't? Which of these variables, if any, should the next project address?
3. Should the PAC mandate be broadened to include the initial provision of contraceptives and the supply of basic medical equipment in an effort to immediately use the training skills of participants?
4. Are there additional gaps in training and education in the PAC IIB project?
5. Workshops have been used extensively in the PAC IIB project to conduct training activities. Are there other approaches that should be used, such as on the job training and self-study?
6. Please comment on the recommendations of the "Issues Paper" as they relate to the future PAC project.

Attachment 2

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Attachment 3

List of Persons Interviewed

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POPTECH

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Attachment 4

Office of Population Questionnaire to Missions Regarding PAC IIB Performance

SUBJECT: POPULATION: EXTERNAL EVALUATION OF FAMILY PLANNING TRAINING WORLDWIDE PARA-MEDICAL, AUXILIARY AND COMMUNITY PERSONNEL PROJECT (PAC IIB)

1. RD/POP/IT IS PLANNING THE SUBJECT EVALUATION FOR EARLY 1993. THIS WILL BE THE FINAL EVALUATION OF THE PROJECT, WHICH ENDS IN 1994. AN INDEPENDENT TEAM WILL EVALUATE CONTRACTOR PERFORMANCE SINCE 1989 BY DEVELOPMENT ASSOCIATES FOR THE LAC, ASIA AND NEAR EAST REGIONS; AND THE PROGRAM FOR INTERNATIONAL TRAINING IN HEALTH (INTRAH) FOR THE AFRICA REGION. THE TEAM WILL GO OUT ON TWO SITE VISITS. THEY WILL USE INFORMATION FROM THE SITE VISITS, INTERVIEWS WITH VARIOUS AID/W STAFF, TELEPHONE INTERVIEWS WITH THE MISSIONS, REVIEWS OF PROJECT DOCUMENTS/REPORTS, AND VISITS TO CONTRACTOR HEADQUARTERS AS THE BASIS FOR THE EVALUATION. INFORMATION FROM THIS EXTERNAL EVALUATION WILL BENEFIT RD/POP IN THE DESIGN OF A FOLLOW-ON PROJECT.

2. FOR MISSIONS WHICH PREVIOUSLY RESPONDED TO THE CABLE REGARDING NEW DIRECTIONS IN EDUCATION AND TRAINING (DIET), WE APPRECIATE YOUR COMMENTS/SUGGESTIONS AND MANY OF THESE WILL BE TAKEN INTO CONSIDERATION FOR A FOLLOW-ON PROJECT.

3. WHILE WE ALSO APPRECIATE THE BURDEN OF YOUR WORKLOAD, FIELD COMMENTS ARE CRUCIAL TO DESIGNING THE NEW PROJECT AND TO UNDERSTANDING THE IMPACT OF THE CURRENT PROJECT. THEREFORE, YOUR BRIEF RESPONSES TO THE FOLLOWING QUESTIONS, RELEVANT TO YOUR PARTICULAR COUNTRY SITUATION, ARE NEEDED. PLEASE FOCUS ON THE SPECIFIC ACTIVITIES OF THE CONTRACTORS IN IMPLEMENTING PAC IIB. RESPONSES MAY BE FORWARDED TO RD/POP/IT EITHER VIA CABLE OR FAX, NO LATER THAN NOVEMBER 22, 1992. FOLLOW-UP PHONE CALLS BY THE EVALUATION TEAM WILL BE MADE IN JANUARY OR FEBRUARY TO

EITHER CLARIFY RESPONSES TO THIS CABLE OR TO GET ORIGINAL DATA IF YOU PREFER TO RESPOND BY PHONE. PLEASE SEND A SCHEDULE FOR THE BEST TIME TO MAKE PHONE CONTACT DURING THOSE MONTHS. ANY ADDITIONAL COMMENTS MISSIONS WISH TO PROVIDE WHICH WILL ASSIST US IN COMPLETING A THOROUGH EVALUATION WILL BE APPRECIATED:

A. WHAT HAS BEEN THE IMPACT OF THE CONTRACTOR ON THE AVAILABILITY OF FAMILY PLANNING TRAINING AND SERVICE DELIVERY?

- B. HOW EFFECTIVE HAVE THE CONTRACTORS BEEN IN INCREASING THE TRAINING CAPABILITIES AND CAPACITY OF DEVELOPING COUNTRY INSTITUTIONS AND AGENCIES IN IN-SERVICE AND PRE-SERVICE PROGRAMS? FOR EXAMPLE, HAVE THE ASSISTED INSTITUTIONS AND AGENCIES BEEN ABLE TO MAINTAIN TRAINING PROGRAMS WITH DECREASED TECHNICAL ASSISTANCE?
- C. WHAT INFLUENCE HAS THE PAC IIB HAD ON FP GUIDELINES, POLICY AND REGULATORY PRACTICES?
- D. ARE THE APPROPRIATE CADRE OF WORKERS SELECTED FOR MAXIMUM IMPACT? ARE THEY TRAINED IN THE APPROPRIATE SKILLS AND RELEVANT COURSES?
- E. WHAT FOLLOW-UP IS PROVIDED AFTER TRAINING? IS IT SUFFICIENT?
- F. WHAT EFFORTS HAVE BEEN MADE TO DEVELOP SYSTEMS (FOR IN-COUNTRY USE) TO: TRACK AND LOCATE TRAINEES, CONDUCT EVALUATIONS, DEVELOP MATERIALS ETC.?
- G. ADDRESS COLLABORATION AND COORDINATION WITH OTHER AGENCIES AND WHETHER THESE EFFORTS NEED TO BE IMPROVED.
- H. ARE REGIONAL OFFICES AND RESIDENT ADVISORS PROVIDING EFFICIENT AND EFFECTIVE PROJECT MANAGEMENT AND TECHNICAL ASSISTANCE? DOES STAFF HAVE THE RIGHT SKILLS MIX AND RELEVANT EXPERIENCE?
- I. IS COMMUNICATION BETWEEN THE CONTRACTORS, MISSIONS, AID/W, REGIONAL OFFICES AND HOST COUNTRIES SATISFACTORY?
- J. HAS THE PROJECT BEEN RESPONSIVE TO MISSION'S NEEDS?
- K. SHOULD THE PAC MANDATE BE BROADENED TO INCLUDE THE INITIAL PROVISION OF CONTRACEPTIVES AND THE SUPPLY OF BASIC MEDICAL EQUIPMENT IN AN EFFORT TO IMMEDIATELY USE THE TRAINING SKILLS OF PARTICIPANTS?

4. THANK YOU FOR YOUR ASSISTANCE WITH THIS EVALUATION. FAXES/CABLES MAY BE TAGGED TO LUCY HIZE OR MARIA BUSQUETS-MOURA. EAGLEBURGER

Appendix B

Selected Features and Progress to Date of INTRAH Training Projects in Eight Focus Countries

Project Features	Burkina Faso	Cameroon	Cape Verde	Kenya (Chogoria)	Rwanda	Tanzania (USAID & UNFPA)	Togo	Uganda
1. Duration of training project	1990-1994	1991-1994	1990-1994	1991-1994	1991-1994	1991-1994	1991-1992	1991-1993
2. Project locus: Ministry of Health other	Yes —	Yes —	Yes —	— Chogoria Hospital	— ONAPO ¹	Yes —	Yes —	Yes —
3. Training strategy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4. Training proposal to A.I.D.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5. Training subcontract	Yes	Yes	Yes	Memo of Agreement	Yes	Yes	Yes	Yes
6. Training plan for: IST PST Linked PST/IST	Yes — footnote 2	Yes In progress In progress	Yes — —	Yes — Yes	Yes — Yes	Yes In progress Yes	Yes — Yes	Yes — Yes
7. Scope of project: nationwide regional district other	— — — Provincial (15 provinces)	In progress — — Provincial (5 provinces)	— — — Islands (8)	— — Yes —	Yes — — —	— Yes — —	Yes — — —	— Yes — —
8. Training locus: program unit in Ministry training unit in Ministry at a training center in an organization none	Yes — — — —	Yes — — — —	Yes — — — —	— — — Yes —	— — Yes Yes —	Yes — — — —	Yes — — — —	Yes — — — —

19

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14

Project Features	Burkina Faso	Cameroon	Cape Verde	Kenya (Chogoria)	Rwanda	Tanzania (USAID & UNFPA)	Togo	Uganda
9. Master or national trainers: team individuals	Yes (18) —	— Yes (20)	No No	No No	— Yes (18)	Yes —	— Yes (15) clinical only	Yes (5) —
10. Capability of master or national trainers: full, according to standards partial, according to standards low, according to standards	— Yes —	— — Yes	N/A	N/A	— — Yes	— Yes —	— Yes —	— Yes —
11. Number of host country trainers in the training project (current)	55	20	N/A	7	N/A	37	15 clinical only	19
12. Number of trainees, to date: as trainers as service providers as preceptors as other Total	106 142 21 205 474	65 74 14 55 208	— 28 14 10 52	18 69 — 1 88	36 102 25 93 256	37 30 — 137 204	— 68 12 76 156	28 166 11 117 322
13. Number of first and second generation trainees	4,740	2,080	520	880	2,560	2,040	1,560	3,220
14. Training selection criteria for each training activity	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
15. Training practice sites	Yes	Yes	Yes	Yes	Partial	Yes	Yes	Yes
16. Training and service linkage	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
17. Job descriptions for service providers	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
18. Standards of practice for service providers	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
19. Guidelines for service provision (protocols)	In progress	Yes	No	Yes	Yes	Yes	Yes	Yes

38

55

Project Features	Burkina Faso	Cameroon	Cape Verde	Kenya (Chogoria)	Rwanda	Tanzania (USAID & UNFPA)	Togo	Uganda
20. Training methodologies used: theoretical experiential/learner-centered demonstration simulation practical/field-based	Yes No Yes Yes Yes	Yes Yes Yes Yes Yes	Yes Yes Yes Yes Yes	Yes Yes Yes Yes Yes	Yes Yes Yes Yes Yes	Yes Yes Yes Yes Yes	Yes Yes Yes Yes Yes	Yes Yes Yes Yes Yes
21. Number of training materials distributed to country	2,121	1,135	172	—	1,953	2,352	5,697 (includes RO/L ⁴)	1,914
22. Curriculum development as part of project	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
23. Training equipment and supplies: sufficient insufficient nil	At nat'l lev. Yes at provin. lev. —	Yes — —	Yes — —	— Yes —	Yes — —	— Yes —	Yes — —	— Yes —
24. Practical sites' equipment and supplies: sufficient insufficient nil	— Yes —	— Yes —	Yes — —	Yes — —	— Yes at prefect. lev. —	— Yes —	— Yes —	— Yes —
25. Budget for training: host country INTRAH	Yes Yes	Yes Yes	Unknown Yes	Yes Yes	Yes Yes	Yes Yes	Yes Yes	Yes Yes

65

56

Project Features	Burkina Faso	Cameroon	Cape Verde	Kenya (Chogoria)	Rwanda	Tanzania (USAID & UNFPA)	Togo	Uganda
26. Training evaluation:								
pre-training assessment	No	No	No	Yes	Partial	In progress	No	Yes
pre/post tests	No	Yes	Yes	Yes	Yes	Yes	No	Yes
skills	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
knowledge	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
training activity evaluation	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
trainee follow-up (at worksite)	Yes	Yes	TBD ⁶	Yes	TBD	Yes	Yes	Yes
performance evaluation	Yes	Yes	TBD ⁶	Yes	Yes	Yes	Yes	Yes
annual and final project reviews	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
impact evaluation	Reporting footnote 5	Reporting footnote 5	No	TBD ⁶	Reporting footnote 5	Reporting	Reporting	Reporting footnote 5
27. Training documentation:								
roster of trainees, by type and date of training	Yes	No footnote 7	Yes footnote 7	Yes	Yes	Yes	footnote 7	Yes
roster of trainers	No	Yes	N/A	Yes	Yes	footnote 7	footnote 7	Yes
roster of training activities	Yes	Yes	Yes	Yes	Yes	footnote 7	footnote 7	Yes
training activity budgets and expenditures	Yes	Yes	Yes	Yes	Yes	footnote 7	footnote 7	Yes
trainee evaluations	Yes	Yes	Yes	Yes	Yes	footnote 7	footnote 7	Yes
training activity evaluations	Yes	Yes	Yes	Yes	Yes	footnote 7	footnote 7	Yes
trainee follow-up results and recommendations	Yes	Yes	TBD	Yes	TBD	Yes	footnote 7	Yes
training activity handouts	Yes	Yes	Yes	Yes	Yes	Yes	footnote 7	Yes

Source: INTRAH

¹National Office of Population²INTRAH works with the central pre-service training (PST) unit in MOH. INTRAH resident coordinator is retired chief of the central PST unit.³Regional Office of Nairobi⁴Regional Office of Lomé⁵Impact studies will be conducted.⁶To be determined⁷This documentation is most reliably found in trip reports. The information is available in-country or in the RO/L, in some form.

Appendix C

Selected Features and Progress to Date of DA Training Projects in 14 Countries in the LAC and ANENA Regions

	Project Duration (in years)	Project Locus	Training Strategy	Training Needs Assessment	Plan For		
					Pre-Service Training	In-Service Training	Linkages
India	3	Prof. Assc.	Y	Y	N	Y	N
Lebanon	2	IPPF	Y	Y	N	Y	N
Philippines	5	NGO	Y	Y	N	Y	N
Tunisia	4	GOT	Y	Y	Y	Y	Y
Turkey	3	MOH	Y	Y	Y	Y	Y
Yemen	3	GOY	Y	Y	N	Y	Y
Bolivia	5	NGC/MOH	Y	Y	Y	Y	Y
Brazil	5	IPPF	Y	Y	Y	Y	N
D. Republic	5	NGO	Y	Y	Y	Y	Y
Ecuador	5	NGO	Y	Y	N	Y	N
Guatemala	5	IPPF	Y	Y	N	Y	N
Mexico	5	MOH	Y	Y	N	Y	N
Nicaragua	4	MOH	Y	Y	Y	Y	Y
Peru	5	MOH	Y	Y	Y	Y	Y

Appendix D

Funding Mechanisms in DA Countries
February 1993

		Bilateral	Buy-In	Central Funding
Priority Countries	India	Yes		Yes
	Turkey	No		Yes
	Philippines	Yes	Feb. 1990 - Sept. 1992	Yes (after 9/92)
	Peru	Yes		Yes
	Mexico	No		Yes
	Brazil	No		Yes
Non-Priority Countries	Bolivia	Yes	Sept. 1990 - Sept. 1994	
	Dominican Republic	Yes		Yes
	Ecuador	Yes		Yes
	Guatemala	Yes		Yes
	Nicaragua	Yes		Yes
	Lebanon	No	Sept. 1991 - Sept. 1992	Yes (after 9/92) ¹
	Tunisia	Yes		Yes
	Yemen	Yes		Yes

Source: DA

¹A small amount of central funding was provided to complete activities undertaken under the bilateral.